

8657

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Lewis Armiger</u>		4. DATE OF DEATH Month Day Year <u>Aug 21 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 6 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AA Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>AA Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WM HENRY ARMIGER</u>		14. MOTHER'S MAIDEN NAME <u>Harriet ANN Webster</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>LOUISE V. JONES, Churchton, MD</u>	
17. INFORMANT Address <u>LOUISE V. JONES, Churchton, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 1959</u> to <u>Aug 21 1959</u> that I last saw the deceased alive on <u>Aug 21 1959</u> and that death occurred at <u>10 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>Shady Side, Md.</u> DATE SIGNED <u>8/22/59</u>	
PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 24 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodfield</u>	22d. LOCATION (City, town, or county) (State) <u>Walesville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 26 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS  
CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
John Doe		Male		45		Jan 1, 1900		New York City	
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED	
Married		Single		Married		Divorced		Widowed	
DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
Jan 1, 1920		New York City		Jan 1, 1920		New York City		Heart Disease	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
Jan 1, 1920		New York City		Heart Disease		Natural		Teacher	
OCCUPATION		MANNER OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
Teacher		Natural		Heart Disease		Natural		Teacher	
MANNER OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
Natural		Heart Disease		Natural		Heart Disease		Natural	
CAUSE OF DEATH		MANNER OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CAUSE OF DEATH	
Heart Disease		Natural		Heart Disease		Natural		Heart Disease	
MANNER OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
Natural		Heart Disease		Natural		Heart Disease		Natural	
CAUSE OF DEATH		MANNER OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CAUSE OF DEATH	
Heart Disease		Natural		Heart Disease		Natural		Heart Disease	

CHIEF CLERK  
BUREAU OF VITALS  
STATE DEPARTMENT OF HEALTH

8658

## CERTIFICATE OF DEATH

08630

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ann<del>e</del> Arundel General Hospital</b>		d. STREET ADDRESS <b>1112 Mitchell St.</b>	
3. NAME OF DECEASED (Type or print) <b>TIMOTHY HOWARD BAKER</b>		4. DATE OF DEATH <b>AUGUST 16 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 9, 1959</b>
9. AGE (In years last birthday) <b>5 yrs.</b>		10. IF UNDER 1 YEAR <b>5 Months 7 Days</b> IF UNDER 24 HRS. <b>Hours Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Annapolis, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas H. Baker</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Britton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Mr. Thomas H. Baker- Father- Same as # 2</b>		Address <b>---</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombia</b> 751X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hydrocephalus</b> DUE TO (c) <b>Spina Bifida</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk 1</b> <b>5 months</b> <b>5 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Meningioma</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 8-16-1959</b> , to <b>Aug 16 1959</b> , that I last saw the deceased alive on <b>8-16-1959</b> , and that death occurred at <b>2:50 PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James R. Martin</b>		M.D. <b>65 HAW ST.</b>	
PHYSICIAN'S NAME (Type) <b>JAMES R. MARTIN</b>		<b>ANNAPOLIS, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-18-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING FUNERAL HOME</b>		ADDRESS <b>Annapolis, Md.</b>	
24a. REC'D BY REGISTRAR <b>AUG 19 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08631

8692

## CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D.C.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		c. LENGTH OF STAY IN 1b <b>19 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>			d. STREET ADDRESS <b>717 Princeton St., N.W.</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Children's Center-District Training School</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Howard</b> Middle <b>Barnes</b> Last <b>Barnes</b>				<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>22</b> Year <b>59</b>			
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>3/23/55</b>	<b>9. AGE</b> (In years last birthday) yrs. <b>3</b>	<b>IF UNDER 1 YEAR</b> Months <b>3</b> Days <b>19</b> Hours <b>59</b> Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>---</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>---</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Washington, D.C.</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		
<b>13. FATHER'S NAME</b> <b>Howard Barnes</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Beatrice Taylor</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>---</b>		<b>16. SOCIAL SECURITY NO.</b> <b>---</b>		<b>17. INFORMANT</b> Address <b>Children's Center, Laurel, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>regurgitation with aspiration</b> DUE TO <b>483x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cerebral palsy, spastic quadriplegia - severe</b> DUE TO (c) <b>mental retardation-severe-post influenza meningitis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2/25/56</b> <b>8/22/59</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour <b>19</b> a. m. <b>---</b> p. m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		<b>20g. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <b>1/17/58</b> , 19 <b>---</b> , to <b>8/22/59</b> , 19 <b>---</b> , that I last saw the deceased alive on <b>8/22/59</b> , 19 <b>---</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <b>James E. Boyland</b>		<b>M.D.</b> <b>Children's Center, Laurel, Md.</b>		<b>ADDRESS</b> (Street, city or town, state) <b>Children's Center, Laurel, Md.</b>		<b>DATE SIGNED</b> <b>8/24/59</b>	
<b>PHYSICIAN'S NAME</b> (Type) <b>James E. Boyland, M.D.</b>		<b>Children's Center, Laurel, Md.</b>		<b>8/24/59</b>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>Aug. 25, 1959</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>District Training School</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Laurel, Maryland</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John J. Jones, Jr.</b>				<b>ADDRESS</b> <b>District Training School</b>		<b>24a. REC'D BY REGISTRAR</b> <b>AUG 27 59</b>	
<b>Laurel, Maryland</b>				<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kline</b>			

10034

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

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10034

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to blurriness.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8693

## CERTIFICATE OF DEATH

08632

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft George G. Meade</b>		c. LENGTH OF STAY IN lb <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Army Hospital</b>		e. STREET ADDRESS <b>3909 Fordleigh Rd</b>	
3. NAME OF DECEASED (Type or print) First <b>Not named</b> Middle <b>BENNETT</b> Last <b>BENNETT</b>		4. DATE OF DEATH Month <b>August</b> Day <b>8</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 Aug 59</b>
9. AGE (In years last birthday) yrs. <b>11</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Arthur M. Bennett</b>		14. MOTHER'S MAIDEN NAME <b>Rhoda Gartnerman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Father</b>		Address <b>Arthur M. Bennett, Baltimore, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.0</b> <b>NO TOXIC</b> <b>Anoxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>8 August</b> , 19 <b>59</b> , to <b>8 August</b> , 19 <b>59</b> that I last saw the deceased alive on <b>8 August</b> , 19 <b>59</b> , and that death occurred at <b>1050A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>8 Aug 59</b>			
ACTUAL SIGNATURE <b>Roger C. Moyer</b> M.D. <b>U.S. ARMY HOSPITAL, FT GEORGE G. MEADE, MD</b>			
PHYSICIAN'S NAME (Type) <b>ROGER C. MOYER, CAPT, MC, US ARMY HOSPITAL, FT MEADE, MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-9-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rosedale</b>	22d. LOCATION (City, town, or county) (State) <b>Balto Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis Inc</b>		ADDRESS <b>2100 Entwistle Place</b>	
24a. REC'D BY REGISTRAR <b>AUG 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Kenna</b>	

2050231XV4

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





8695

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Albany</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <i>Maryland</i> COUNTY <i>Albany</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>East Port</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>East Port</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>328 4th St. East Port</i>		d. STREET ADDRESS <i>1528-4th Street.</i>	
3. NAME OF DECEASED (Type or print) <i>Lily Elizabeth Bras</i>		4. DATE OF DEATH Month <i>8</i> Day <i>13</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-11-1876</i>
9. AGE (In years last birthday) <i>83</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>John Wesley Mothers</i>		14. MOTHER'S MAIDEN NAME <i>Lucinda Harris</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Bladys Harris 200 West St.</i>	
17. INFORMANT <i>Bladys Harris 200 West St.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension &amp; Generalized</i> DUE TO (c) <i>arteriosclerosis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>3 mos</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5-8-59</i> , to <i>8-13-59</i> , that I last saw the deceased alive on <i>8-11-59</i> , 19 <i>59</i> , and that death occurred at <i>6:15</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. T. Allen</i>		DATE SIGNED <i>8-15-59</i>	
PHYSICIAN'S NAME (Type) <i>A. T. ALLEN</i>		ADDRESS (Street, city or town, state) <i>42 Cathedral St. Annapolis, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-16-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Union Chapel</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reesett, Anna Mc</i>		24a. REC'D BY REGISTRAR <i>SEP 15 '59</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Carlton S. Kline</i>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8694

## CERTIFICATE OF DEATH

08633

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>AA</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SHADYSIDE</b>		c. LENGTH OF STAY IN 1b <b>6 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>SHADYSIDE</b>	
3. NAME OF DECEASED (Type or print) <b>JOHN ALFRED BING</b>		4. DATE OF DEATH <b>August 11 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/17/79</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WAYNE W. VA</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>FRANK BING</b>		14. MOTHER'S MAIDEN NAME <b>Augusta Davis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>John L BING</b> Address <b>SHADYSIDE MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 4 <b>DUPLICATE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>immediate years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 1959</b> to <b>August 11, 1959</b> , that I last saw the deceased alive on <b>August 1, 1959</b> , and that death occurred at <b>12 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Willard F Smith</b> M.D.		ADDRESS (Street, city or town, state) <b>Shady Side, Md</b> DATE SIGNED <b>8/11/59</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	22b. DATE THEREOF <b>AUG 13 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodfield</b>	22d. LOCATION (City, town, or county) (State) <b>Edlesville MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard Hardaway Edlesville Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 13 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CROWNSVILLE STATE HOSPITAL</b> <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>KENT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CROWNSVILLE</b>		c. LENGTH OF STAY IN 1b <b>2 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>CROWNSVILLE STATE HOSPITAL</b>		d. STREET ADDRESS <b>RURAL</b>	
3. NAME OF DECEASED (Type or print) <b>Charles</b> First <b>Justin</b> Middle <b>BROWN</b> Last		4. DATE OF DEATH Month <b>8</b> Day <b>8</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/20/1878</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proprietor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Brown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>INFORMANT</b>	
17. Address <b>Gertrude Bright - Worton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Recurrent Myocardial Infarct.</b> + 200.1 DUE TO (b) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>Generalized and Cerebral Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Ulcers.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/8/59</b> to <b>8/8/59</b> , that I last saw the deceased alive on <b>8/8/59</b> , and that death occurred at <b>11:15 A.M.</b> from the causes and on the date stated above. DOES (Street, city, town, state) DATE SIGNED <b>Crownsville State Hospital</b> <b>8/9/59</b> M.D. <b>Crownsville Md</b>			
ACTUAL SIGNATURE <b>Loney McHenry M.D.</b>		PHYSICIAN'S NAME (Type) <b>Crownsville Md</b>	
22a. BURIAL, CREMAT., OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/11/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fountain Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Chestertown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth Waller</b>		24a. REC'D BY REGISTRAR <b>Arthur S. Hume</b>	
ADDRESS <b>Chestertown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	
DATE <b>AUG 11 '59</b>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

ANNIE ARNOLD  
(Chronic) STATE HOSPITAL

CHESTER  
KENT

GRANDVILLE  
STATE HOSPITAL

KENT

GRANDVILLE  
STATE HOSPITAL

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GRANDVILLE  
STATE HOSPITAL



8697

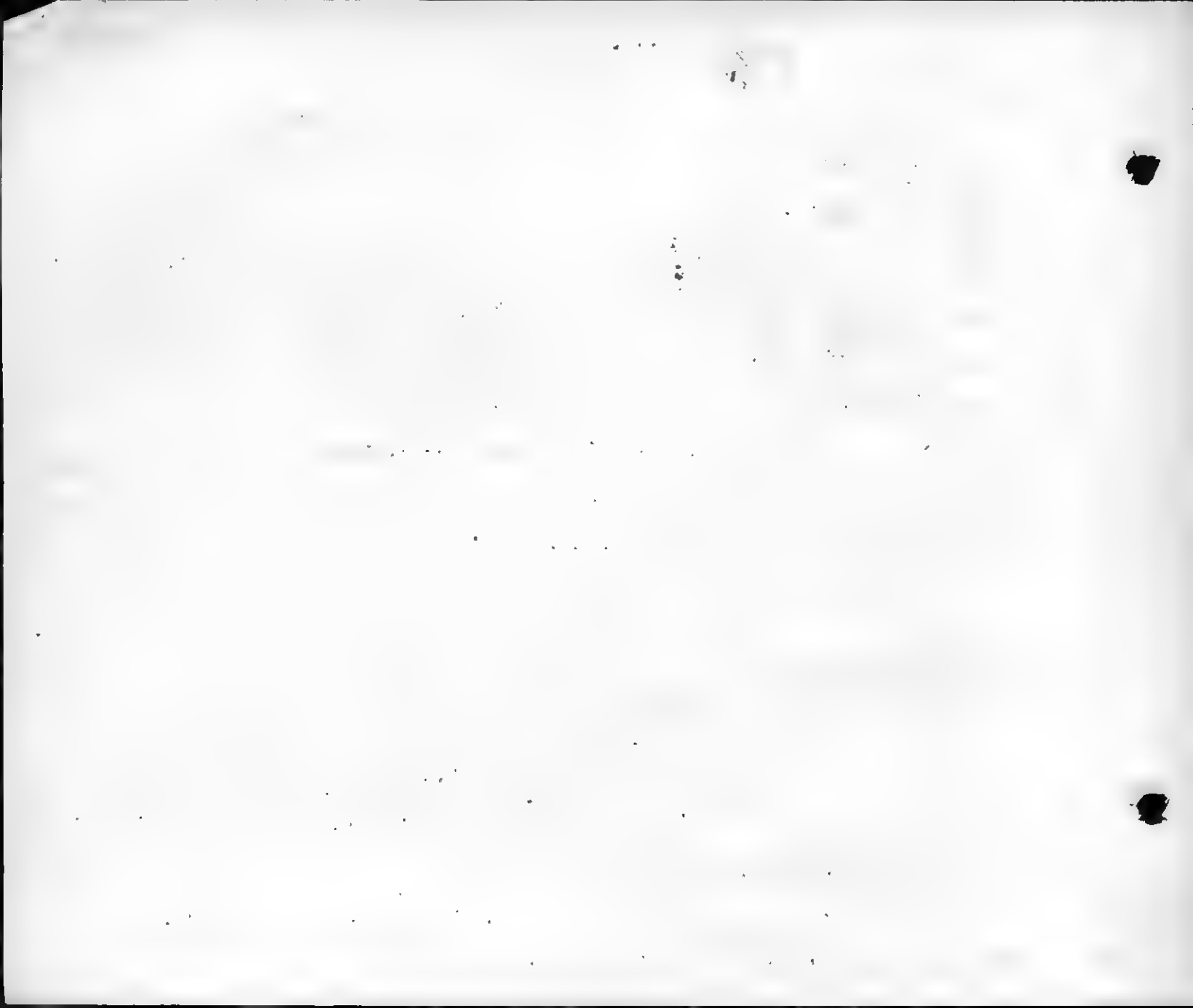
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN lb. <u>8 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>406 - O Street S.E.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emory Earl Brumwell</u>				4. DATE OF DEATH Month Day Year <u>August 31st 19 59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/2/89</u>		9. AGE (In years last birthday) <u>69</u> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafood Merchant.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Tilghman Island</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Edward Brumwell</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Lee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>				16. SOCIAL SECURITY NO. <u>214-32-6623</u>		17. INFORMANT <u>Mrs. Lottie F. Brumwell (wife)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>General Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> <u>2</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Glen Burnie, Md.</u>	
20f. (City or town) <u>Glen Burnie, Md.</u>				20g. (County) <u>Glen Burnie, Md.</u>		20h. (State) <u>Glen Burnie, Md.</u>	
21. I certify that I attended the deceased from <u>February 19 59</u> to <u>8/31/59</u> , that I last saw the deceased alive on <u>8/28/59</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>				DATE SIGNED <u>8/31/59</u>			
PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping &amp; Kirkley, Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Farnsworth</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8698

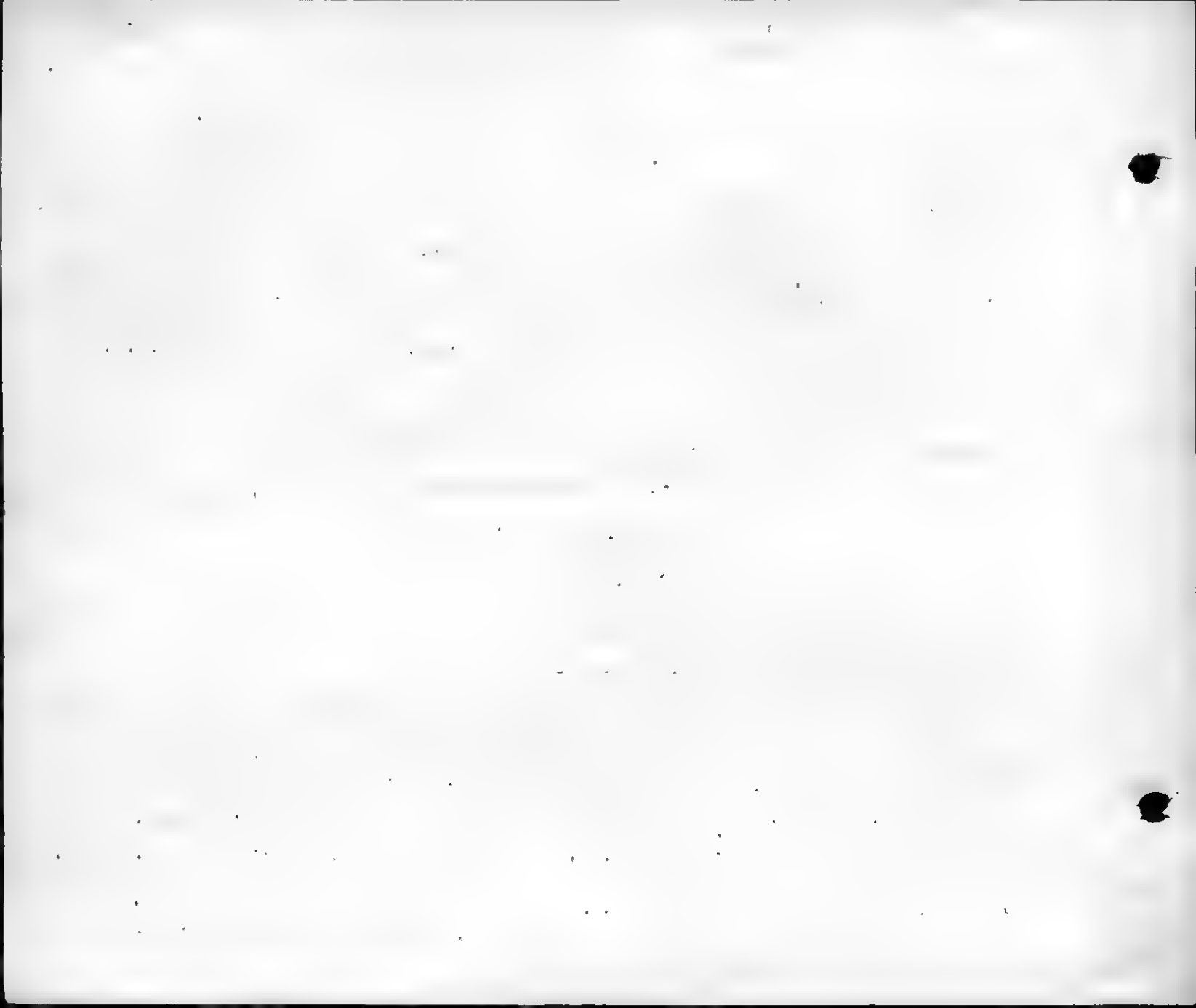
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN lb <b>1mo. 1day</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>230 Beale Court</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Melvin</b>		First		Middle		Last <b>Campher</b>		4. DATE OF DEATH Month <b>8</b>		Day <b>18</b>		Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1881</b>		9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		INFORMANT <b>Hospital Records</b>		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>571.1</b> DUE TO <b>Hypostatic Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Dehydration and Inanition</b> DUE TO (c) <b>Diarrhea</b>		INTERVAL BETWEEN ONSET AND DEATH													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchoiectasis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>													
20c. TIME OF INJURY Month, Day, Year Hour a m. <b>-----</b> 19 p. m. <b>-----</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) <b>-----</b>		(County) <b>-----</b>		(State) <b>-----</b>					
21. I certify that I attended the deceased from <b>7/17</b> , 19 <b>59</b> , to <b>8/18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/18</b> , 19 <b>59</b> , and that death occurred at <b>3:20 P.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b>		DATE SIGNED <b>8/18/59</b>											
ACTUAL SIGNATURE <b>Lionel McHenry Mapp, M. D.</b>		M.D. <b>Crownsville State Hospital, Md.</b>		DATE SIGNED <b>8/18/59</b>											
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>		M.D. <b>Crownsville State Hospital, Md.</b>		DATE SIGNED <b>8/18/59</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/22/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MR. Calvary Cem.</b>		22d. LOCATION (City, town, or county) <b>Cedar Hill</b>		(State) <b>Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>E.O. Wilson</b>		ADDRESS <b>1000 Branthey Ave.</b>		24a. REC'D BY REGISTRAR <b>SEP 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>									

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



8659

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G246 8/6/59 inv

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A A</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Penn</i> b. COUNTY <i>Johnston</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>A A General Hosp</i>		d. STREET ADDRESS <i>714 Sherman St</i>	
3. NAME OF DECEASED (Type or print) <i>Michael</i> First <i>Coco</i> Last		4. DATE OF DEATH Month <i>8</i> - Day <i>2</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 1st 1893</i>
9. AGE (In years last birthday) <i>66</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shoe maker Ret.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Shoe maker</i>	
11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Carmelo Coco</i>		14. MOTHER'S MAIDEN NAME <i>Mary Gallo</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes, give way or dates of service) <i>World War I</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Samuel M Coco</i> Address <i>604 Fieldston Ave Johnston Pa.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Artery</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>Sudden</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> SECONDARY <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While on work <input type="checkbox"/> Not while on work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-5-1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Anthony</i>		22d. LOCATION (City, town, or county) <i>Johnston Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Fayat &amp; Sons</i> ADDRESS <i>Annapolis, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 4 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 1 should be used on a burial-transit permit. File pages 1 and 2 with the registrar prior to burial; cremation, removal.





8699

## CERTIFICATE OF DEATH

Reg. Dist. No.

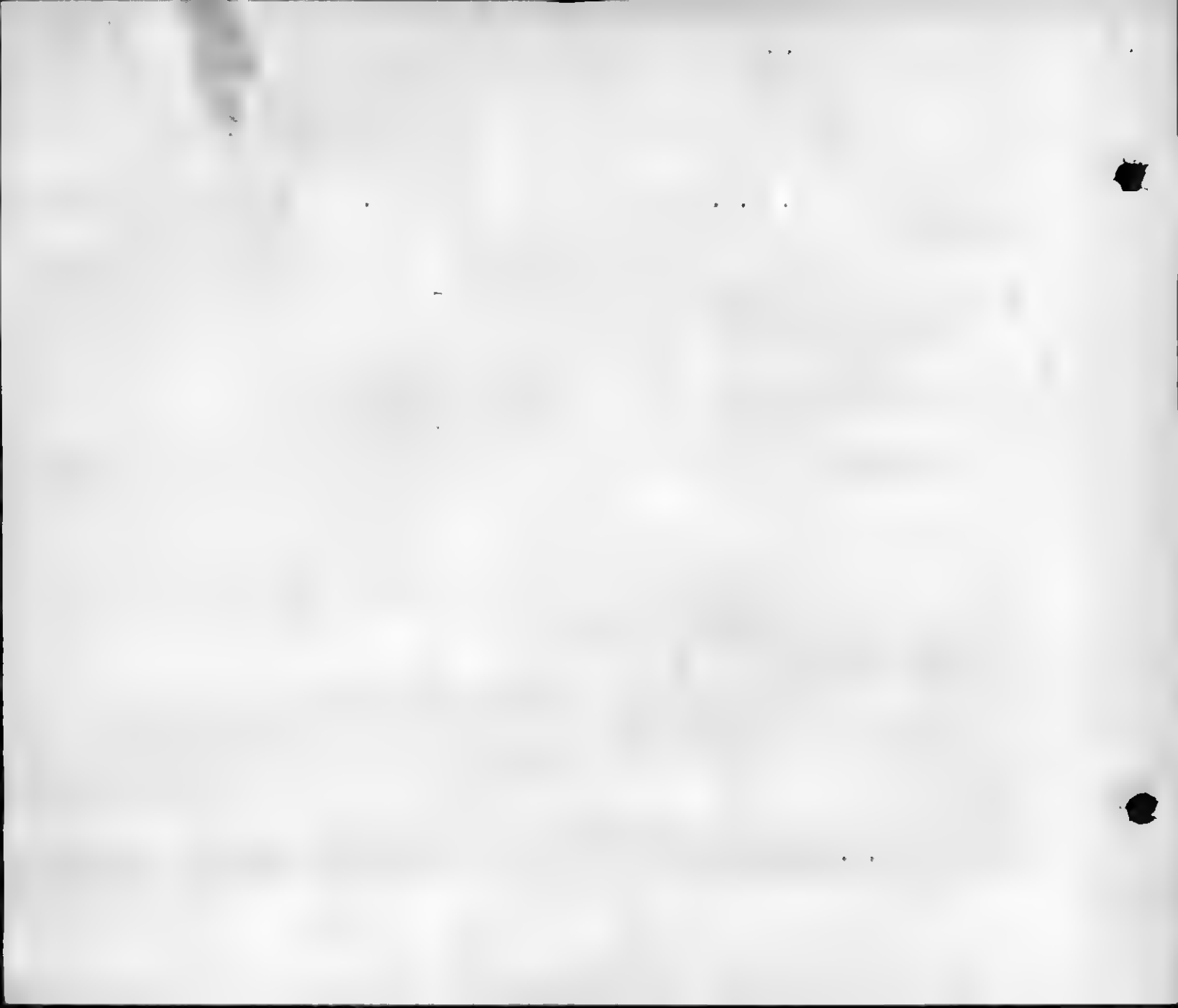
08638

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Office of Dr. R.M. McLaughlin</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Oscar</b> Middle <b>Comhaire</b> Last <b>Comhaire</b>		4. DATE OF DEATH Month <b>8</b> Day <b>4</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-18-92</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>439-20-1070</b>	
17. INFORMANT <b>Mrs. Willette Comhaire</b> Address <b>Same as #2</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute ventricular fibrillation</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cardiac decompensation</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>2 months</b> <b>2 years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 27, 1959</b> , to <b>August 4, 1959</b> , that I last saw the deceased alive on <b>August 4, 1959</b> , and that death occurred at <b>MD</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Pasadena, Md.</b> DATE SIGNED <b>Aug 4, 1959</b>			
ACTUAL SIGNATURE <b>R.M. McLaughlin</b> M.D.		PHYSICIAN'S NAME (Type) <b>R.M. McLaughlin</b> <b>Rt 8 Box 142, Pasadena, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	22b. DATE THEREOF <b>August 8, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>	22d. LOCATION (City, town, or county) (State) <b>Glen Burnie Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.V. Singleton</b> ADDRESS <b>Glen Burnie, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 10 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles E. Kneel</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8660

## CERTIFICATE OF DEATH

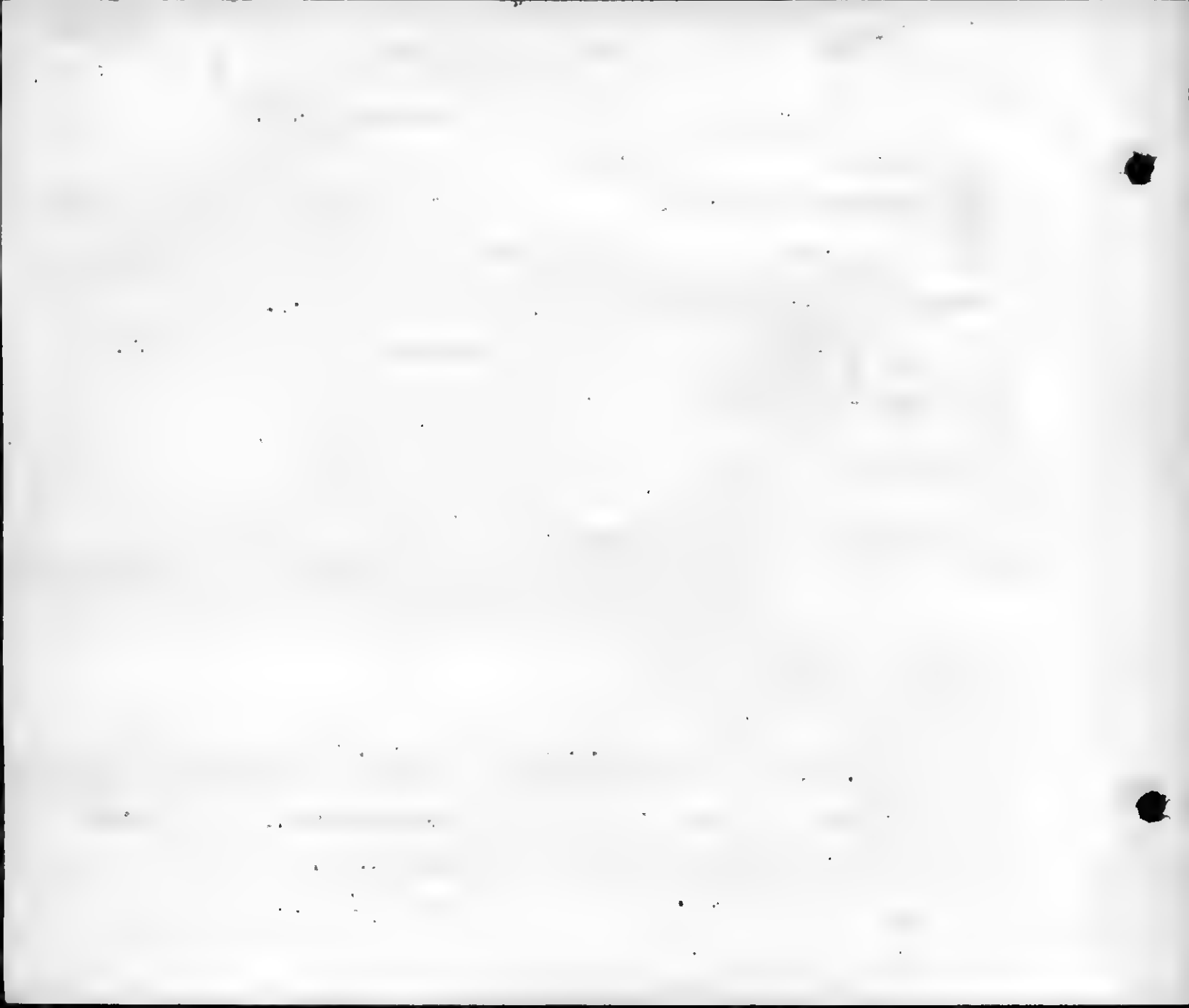
08639

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Washington, D. C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. STREET ADDRESS <b>5411 Ludlow Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Jeanette</b> Middle <b>CONNELL</b> Last		4. DATE OF DEATH Month <b>August</b> Day <b>18</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 2, 1896</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR: Months <b>6</b> Days <b>2</b> Hours <b>0</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Alabama</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>WILLIAM DEBARDEJAGEN</b>		14. MOTHER'S MAIDEN NAME <b>ADELAIDE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>JOSEPH WILLIAMS - 5411 LUDLOW DR WASH DC</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Embolism</b> 4-2-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic Cardio Vascular Disease</b> DUE TO (c) <b>Auricular Fibrillation</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>many years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug. 14, 1959</b> , to <b>Aug. 17, 1959</b> that I lost saw the deceased alive on <b>Aug. 17, 1959</b> , and that death occurred at <b>6:55AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>31 Southgate Ave., Annapolis, Md.</b> DATE SIGNED <b>8/18/59</b>			
ACTUAL SIGNATURE <b>Maurice Klawans</b> M.D.		DATE SIGNED <b>8/18/59</b>	
PHYSICIAN'S NAME (Type) <b>Maurice Klawans</b>		ADDRESS <b>Annapolis, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>8-21-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CRESTLAWN CEMT</b>	22d. LOCATION (City, town, or county) (State) <b>ATLANTA GA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. W. Zelo Sen - Wash. D. C.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 24 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Traversa</b>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8661

## CERTIFICATE OF DEATH

Reg. Dist. No.

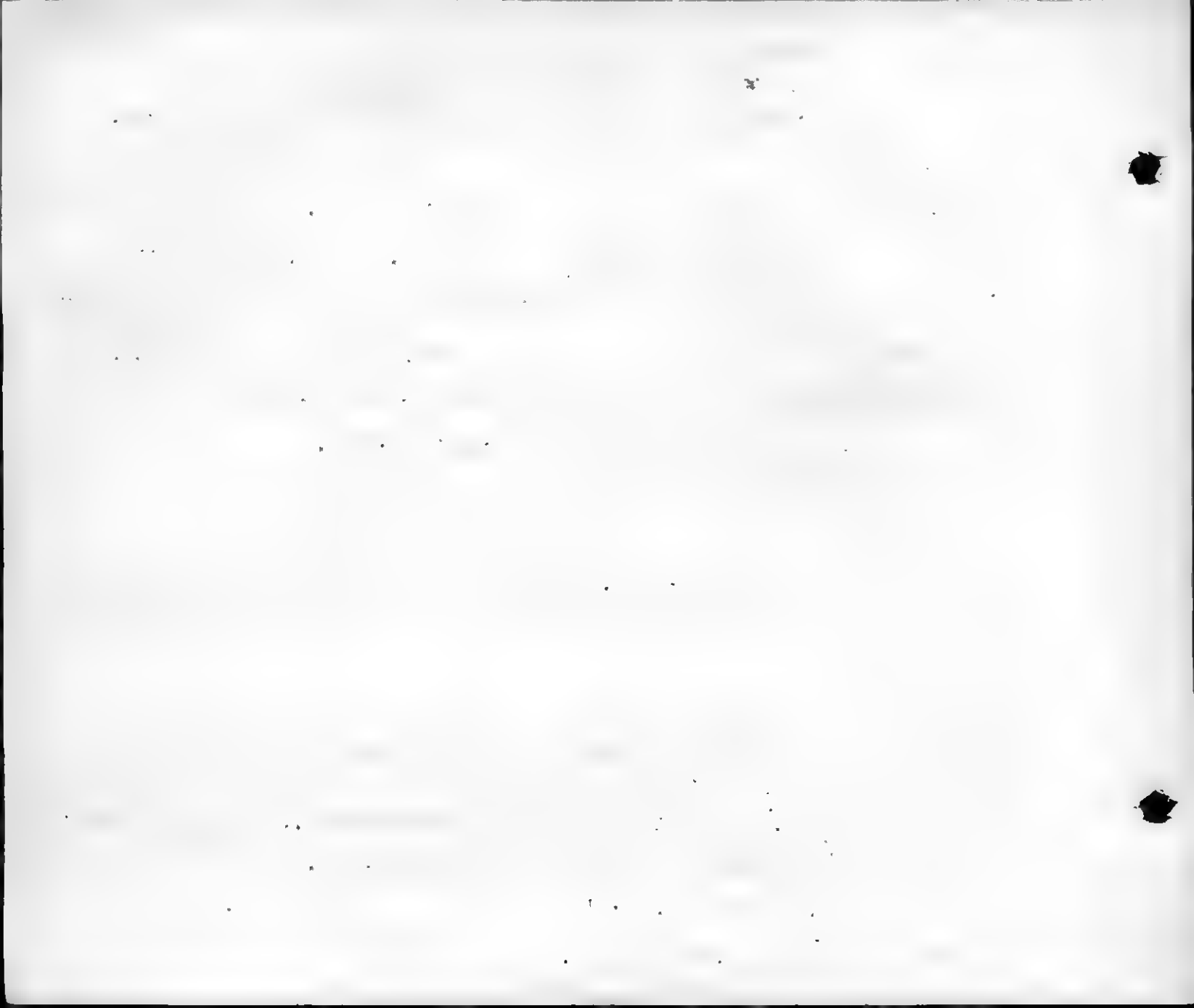
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			
c. LENGTH OF STAY IN 1b <b>1 day</b>				d. STREET ADDRESS <b>159 Jefferson St.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Calvin</b> Last <b>COOK, Jr.</b>				4. DATE OF DEATH Month <b>August</b> Day <b>11</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 10, 1959</b>	9. AGE (In years last birthday) yrs. <b>1</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>3</b> Hours <b>23</b> Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Newborn</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Robert Calvin COOK</b>				14. MOTHER'S MAIDEN NAME <b>Loretta Marie HAMBRUCH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		INFORMANT Address <b>Hospital records.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>773.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Hyaline Membrane Disease</b> (c) <b>Hyaline Membrane Disease</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 10, 1959</b> , to <b>August 11, 1959</b> , that I last saw the deceased alive on <b>August 11, 1959</b> , and that death occurred at <b>11:55 AM</b> , from the causes and on the date stated above.							
ACTUAL DEATH SITE <b>Clayton Norton M.D.</b>				ADDRESS (Street, city or town, state) <b>95 Cathedral St.,</b>		DATE SIGNED <b>8/12/59</b>	
PHYSICIAN'S NAME (Type) <b>Clayton Norton</b>				Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 13, 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Anne's</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>				ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 14 59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Carlton S. Hous</b>			

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Page 4

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





8662

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Co.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas. Hopper-Cosden</u>		4. DATE OF DEATH <u>8-4-59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21 1900</u> 59 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Truck</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harper Cosden</u>		14. MOTHER'S MAIDEN NAME <u>Susan M. Donlin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Douglas - Nancy Koehler</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Emphysema &amp; COPD Pulmonary</u> DUE TO (c) <u>Polyphthemia</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> 19 to <u>1959</u> 19, that I last saw the deceased alive on <u>8-4-59</u> 19, and that death occurred on <u>10 AM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Robert R. HAHN</u>		ADDRESS (Street, city or town, state) <u>Severna Park 8-4-59</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		DATE SIGNED <u>WHL</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 7-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnee Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		24a. REC'D BY REGISTRAR <u>5</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	
ADDRESS <u>Annapolis Md</u>		DATE <u>AUG 6</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8700

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Q. Q.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE <i>Md</i> b. COUNTY <i>Q. Q.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arnold</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>Walter R. Cox</i>		4. DATE OF DEATH <i>Aug 9 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 22-1880</i>
9. AGE (In years lost birthday) <i>78</i>		IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist Ret</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>R. R. Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Q. Q. Co Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Isaac N. Cox</i>		14. MOTHER'S MAIDEN NAME <i>Elvira Wilson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Bertha G. Cox</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of Prostate</i> <i>177X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Metastasis</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>1 yr +</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>January 30, 1959</i> to <i>August 9, 1959</i> , that I last saw the deceased alive on <i>August 8, 1959</i> , and that death occurred at <i>5:30 A.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Maurice K. Klawans</i> M.D.		ADDRESS (Street, city or town, state) <i>31 Southgate Ave</i>	
PHYSICIAN'S NAME (Type) <i>MAURICE F. KLAWANS</i>		<i>Lincoln Park Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>Aug 11-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Ashbury Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Arnold Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis Md</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Carlton S. Hines</i>	
DATE <i>AUG 12 '59</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8663

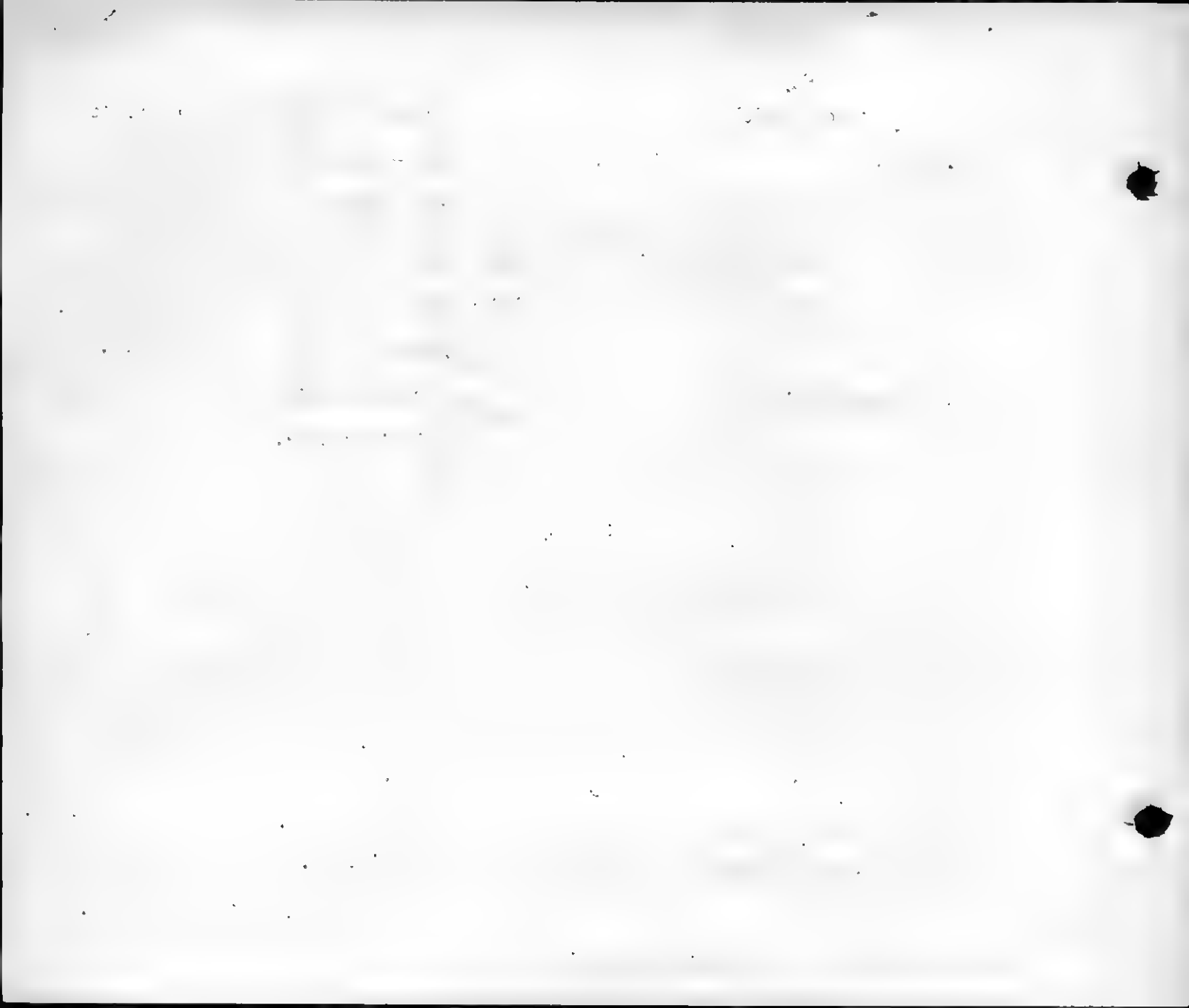
CERTIFICATE OF DEATH

08643

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. STREET ADDRESS <b>Epping Forest</b>	
3. NAME OF DECEASED (Type or print) First <b>Unnamed male infant</b> Middle <b>Crouch</b> Last <b>Crouch</b>		4. DATE OF DEATH Month <b>August</b> Day <b>14</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 12, 1959</b>
9. AGE (In years last birthday) yrs <b>1</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>23</b> Hours <b>5</b> Min <b>5</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Newborn</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Arthur Vernon CROUCH</b>		14. MOTHER'S MAIDEN NAME <b>Peggy O'Neal HILLIARD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO NE</b>	
INFORMANT <b>Hospital records.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>773.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Schewedanna</b> (c) <b>Prematurity</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August 12, 19 59</b> to <b>August 13, 19 59</b> that I last saw the deceased alive on <b>August 13, 19 59</b> and that death occurred at <b>1:50 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C Clayton Norton</b>		ADDRESS (Street, city or town, state) <b>95 Cathedral St.,</b>	
PHYSICIAN'S NAME (Type) <b>Clayton Norton</b>		DATE SIGNED <b>8/14/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>8-15-59</b>		22b. DATE THEREOF <b>8-15-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST MEM. CEM.</b>		22d. LOCATION (City, town or county) (State) <b>ANNAPOLIS MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN M. TAYLOR &amp; SONS ANNAPOLIS MD</b>		24a. REC'D BY REGISTRAR <b>AUG 17 '59</b>	
ADDRESS <b>ANNAPOLIS MD</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. It may be retained in the hospital or funeral home for a period of 10 days after the death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08644						
8701										CERTIFICATE OF DEATH						
										Reg. Dist. No.						
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>ANNE ARUNDEL</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERN - RFD</u>					c. LENGTH OF STAY IN 1b <u>13 Yrs</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERN R.F.D. - Clarks Station</u>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Clarks Station</u>					d. STREET ADDRESS <u>Evergreen Rd. Rt. 10</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Ella May Davenport</u>					4. DATE OF DEATH <u>Aug 29 1959</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>25 Aug 1864</u>		9. AGE (In years last birthday) <u>95</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (Ret) Own Home</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>					11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(UNKNOWN) Null</u>					14. MOTHER'S MAIDEN NAME <u>Rebecca (unknown)</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>NO</u> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO <u>NONE</u>					17. INFORMANT <u>Mrs. Lillian May Cooper</u> Address <u>Same as Not 2</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>intericardiac Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug 25, 1959</u> to <u>Aug 29, 1959</u> , that I last saw the deceased alive on <u>Aug 25, 1959</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above.																
ACTUAL SIGNATURE <u>Edmund J. Bennett</u>					ADDRESS (Street, city or town, state) <u>6236-17th Md</u>					DATE SIGNED <u>8-31-59</u>						
PHYSICIAN'S NAME (Type) <u></u>																
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>31 Aug 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u>						
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert P. Ware</u>					ADDRESS <u>Glen Burnie</u>					24a. REC'D BY REGISTRAR <u>SEP 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. A. S. Hanna</u>				



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8702

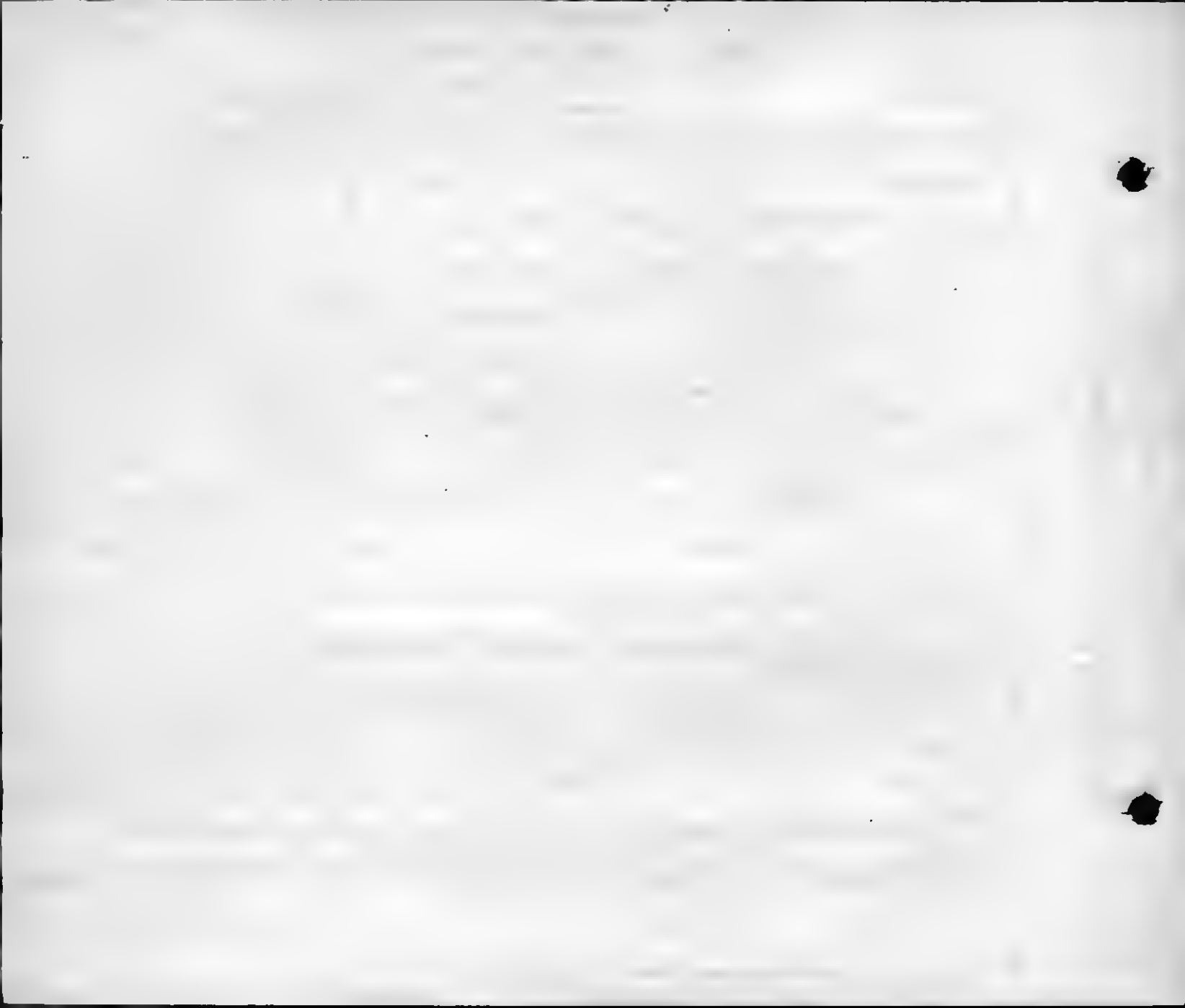
## CERTIFICATE OF DEATH

06645

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>AA.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVERA BEACH</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVERA BEACH</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>235 Carroll Rd</u>		d. STREET ADDRESS <u>235 Carroll Rd</u>	
3. NAME OF DECEASED (Type or print) <u>MARGARET MARY DILLON</u>		4. DATE OF DEATH <u>AUG 1 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-20-99</u>
9. AGE (in years, last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Alvin Hatten</u>		14. MOTHER'S MAIDEN NAME <u>Josephine</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Family name</u>	
17. INFORMANT <u>Family name</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>415X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>RHEUMATIC MYOCARDITIS</u> DUE TO (c) <u>CARDIAC DECOMPENSATION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 YRS.</u> <u>1 YEAR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>AURICULAR FIBRILLATION</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>MOUNTAIN RD.</u> DATE SIGNED <u>8-1-59</u>			
ACTUAL SIGNATURE <u>Arthur Lankford Jr.</u>		M.D. <u>PASADENA, MARYLAND</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR.</u>		<u>PASADENA, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>8-4-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Heaven PK</u>	22d. LOCATION (City, town, or county) (State) <u>Balto.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McClary Funeral Home</u>		ADDRESS <u>130 E. Fort Ave.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send page 3 to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8664

Items 8,9 111.32-6 8-11-59 et  
CERTIFICATE OF DEATH

08646

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN IS <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>				d. STREET ADDRESS <u>Frederick &amp; Cathedral Sts.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Dorsey</u> Last <u>Dorsey</u>				4. DATE OF DEATH Month <u>8</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/26/1886</u>	
9. AGE (In years lost birthday) <u>72 1/2</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Clay Dorsey</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Owen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>270</u>		17. INFORMANT <u>Mrs. Pearl Phelps</u> Address <u>471 W. 147th Street</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Arteriosclerosis (Sclerosis)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Hypertension</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 21, 1959</u> to <u>July 31, 1959</u> , that I last saw the deceased alive on <u>July 15, 1959</u> , and that death occurred at <u>110 - Cherry Street</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. L. D. [Signature]</u>				DATE SIGNED <u>8/3/59</u>			
PHYSICIAN'S NAME (Type) <u>C. E. Hicks III</u>				M.D. <u>110 - Cherry Street</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Hicks III</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8703

## CERTIFICATE OF DEATH

Reg. Dist. No.

08648

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Glen Burnie (Gibson Island)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>95 Broadwater Way</u>		d. STREET ADDRESS <u>95 Broadwater Way</u>	
3. NAME OF DECEASED (Type or print) First <u>Page</u> Middle <u>Edmunds</u> Last <u>Edmunds</u>		4. DATE OF DEATH <u>August 7 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 9, 1922</u>
9. AGE (In years last birthday) <u>37</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Page Edmunds</u>		14. MOTHER'S MAIDEN NAME <u>Susan Cowart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Page Edmunds, Gibson Island Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage from tongue base</u> <u>141.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of tongue</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u> <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 3, 1959</u> to <u>August 7, 1959</u> , that I last saw the deceased alive on <u>August 7, 1959</u> , and that death occurred at <u>3:58 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Kathleen H. Lyons</u> M.D.		ADDRESS (Street, city or town, state) <u>Paisley Rd. Gibson Island</u>	
PHYSICIAN'S NAME (Type) <u>Kathleen H. Lyons</u>		DATE SIGNED <u>8/7/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/10/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry J. [illegible]</u> ADDRESS <u>12 [illegible]</u>		24a. REC'D BY REGISTRAR <u>August 10 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	





8665

CERTIFICATE OF DEATH

Reg. Dist. No.

08649

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>714 MONTEREY AVE.</u>				d. STREET ADDRESS <u>203 FARRAGUT RD</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>William H. Ellinghausen</u>				4. DATE OF DEATH <u>August 17 1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-15-1892</u>	
9. AGE (In years, lost birthday) <u>66</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CIVIL SERVICE</u>			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>HERMAN ELLINGHAUSEN</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN MYERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, (If yes, give war or date of service) <u>NO</u>				16. SOCIAL SECURITY NO <u>NO</u>			
17. INFORMANT <u>ROSE I. ELLINGHAUSEN #2</u>				Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>157X</u> DUE TO <u>Carcinoma of Pancreas</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour o. m. <u>  </u> p. m. <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>							
21. I certify that I attended the deceased from <u>Aug 11</u> 19 <u>58</u> to <u>8-17</u> 19 <u>59</u> , that I last saw the deceased alive on <u>8-17</u> 19 <u>59</u> , and that death occurred at <u>8:40</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6 SHAW ST. ANNAPOLIS, MD</u> DATE SIGNED <u>8-18-59</u>							
ACTUAL SIGNATURE <u>James R. Martin</u>				M.D. <u>  </u>			
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>				<u>ANNAPOLIS, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-19-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		22d. LOCATION (City, town, or county) <u>ANNAPOLIS</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Foyt &amp; Sons</u> ADDRESS <u>ANNAPOLIS, MD</u>				24a. REC'D BY REGISTRAR <u>  </u> DATE <u>AUG 20 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8704

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Best Gate</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Best Gate</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>140 Best Gate Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Tracie Fay Kingston</u>				4. DATE OF DEATH <u>8 23 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-10-1885</u>	
9. AGE (In years last birthday) <u>73</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Clarkton, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Blue</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Annies B. Brashears</u>				Address <u>Best Gate Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>11-14-59</u> to <u>8-23-59</u> , that I last saw the deceased alive on <u>8-21-59</u> , 19 <u>59</u> , and that death occurred at <u>6:15</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. T. Allen</u> M.D.				ADDRESS (Street, city or town, state) <u>612 Cathedral ST</u> DATE SIGNED <u>8-28-59</u>			
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-26-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fowlers</u>		22d. LOCATION (City, town, or county) (State) <u>Best Gate, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. Annap. Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>AUG 25 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. B. Kiana</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
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15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

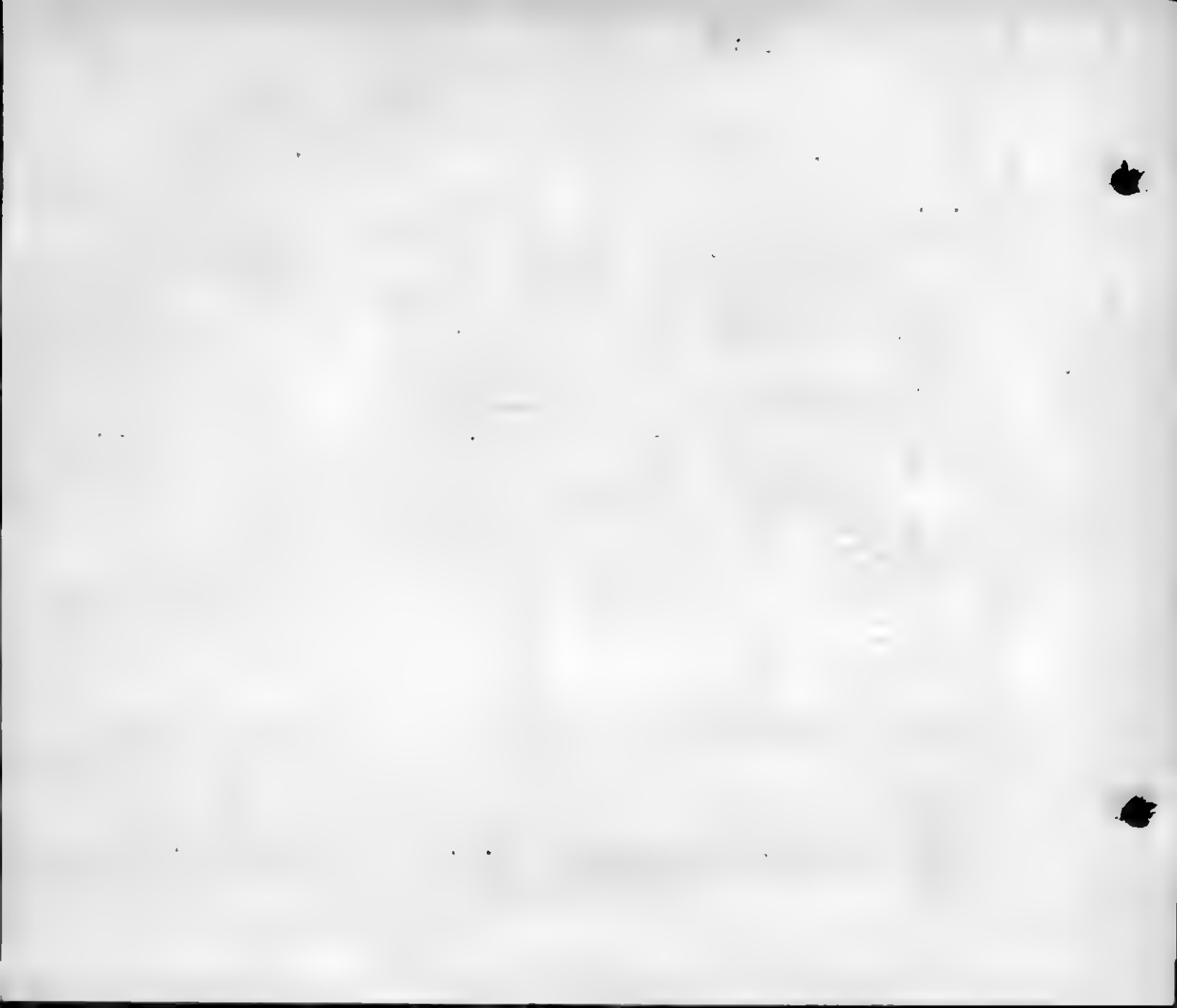
8705

CERTIFICATE OF DEATH

08651

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort George G. Meade</b>		c. LENGTH OF STAY IN TB <b>4 mths</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort George G. Meade</b>		X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. ARMY HOSPITAL</b>		d. STREET ADDRESS <b>7821 Harris Loop</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>Myrtle</b> Last <b>FRANKLIN</b>		4. DATE OF DEATH Month <b>August</b> Day <b>22</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>25 April 1888</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Isaac Phillips</b>		14. MOTHER'S MAIDEN NAME <b>Anna Wilson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Dale A. Angers</b>		Address <b>7821 Harris Lp Ft Geo.G.Meade, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>22 August, 1959</b> , to <b>22 August, 1959</b> , that I last saw the deceased alive on <b>22 August, 1959</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Bernard W. Baron</b> M.D. <b>U. S. ARMY HOSP. FT GEORGE G. MEADE, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/26/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort George G. Meade</b>		22d. LOCATION (City, town or county) (State) <b>Fort George G. Meade, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert W. Baron</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	



8706

08652

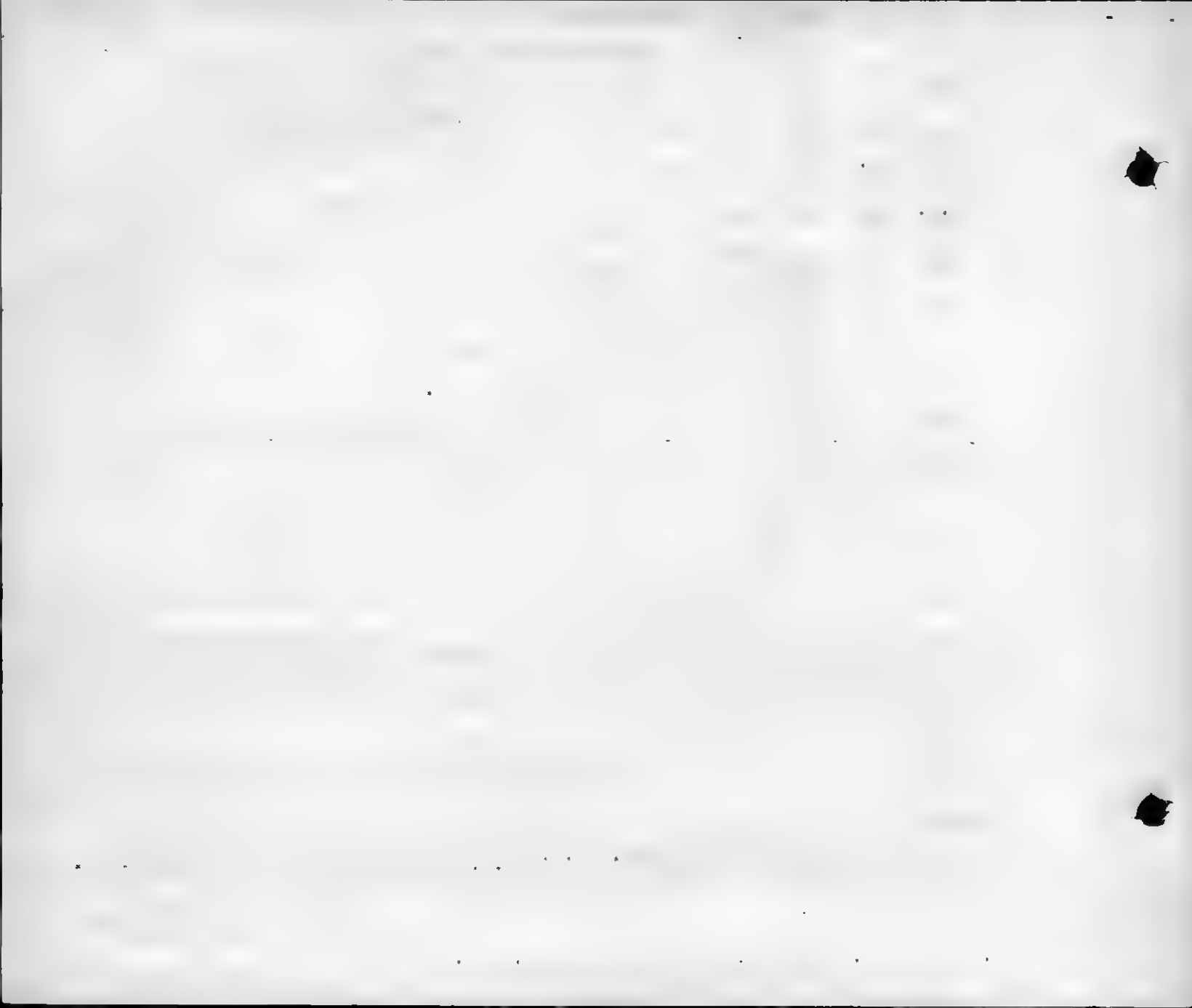
CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft George G. Meade</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Ft George G Meade</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Army Hospital</b>		d. STREET ADDRESS <b>/1807-C Patton Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Not Named</b> Middle <b>Fried</b> Last <b>Fried</b>		4. DATE OF DEATH Month <b>August</b> Day <b>14</b> Year <b>19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>14 Aug 1959</b>
9. AGE (In years last birthday) <b>1</b> yrs		IF UNDER 1 YEAR Months <b>1</b> Days <b>20</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Irving Fried</b>		14. MOTHER'S MAIDEN NAME <b>Joyce C. Rost</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO <b>—</b>	
17. INFORMANT <b>(Father) Irving Fried</b>		Address <b>1807-C Patton Drive</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> <b>776x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>14 Aug</b> , 19 <b>59</b> to <b>14 Aug</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>14 Aug</b> , 19 <b>59</b> , and that death occurred at <b>2050P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Roger C. Moyer</b> M.D.			
PHYSICIAN'S NAME (Type) <b>ROGER C. MOYER, Capt., M.C. U.S. Army Hospital Ft Geo G Meade, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>8/15/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street, Balto. 2, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 18 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Munn</b>

2050272XVD

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



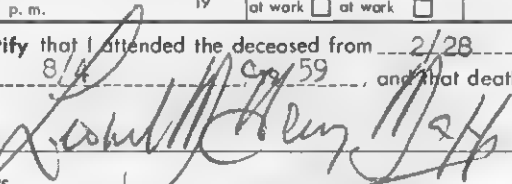




8707

## CERTIFICATE OF DEATH

08653

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>5 mo. 4 years 6 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b> d. STREET ADDRESS <b>15 Locust Street</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Eva</b> First <b>Gibson</b> Last		4. DATE OF DEATH <b>8</b> Month <b>4</b> Day <b>19 59</b> Year					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1891</b>	9. AGE (In years last birthday) <b>68</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
13. FATHER'S NAME <b>George Gibson</b>			14. MOTHER'S MAIDEN NAME <b>Josephine</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT <b>Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia and Anemia</b> <b>171</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Carcinoma of the Cervix</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Malnutrition and Dehydration - Left Inguinal Hernia</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----- (County) (State)			
21. I certify that I attended the deceased from <b>2/28</b> , 19 <b>55</b> , to <b>8/4</b> , 19 <b>59</b> that I lost saw the deceased alive on <b>8/4</b> , 19 <b>59</b> , and that death occurred at <b>12:15</b> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>8/4/59</b>							
ACTUAL SIGNATURE 		M.D. <b>Crownsville State Hospital, Md.</b> <b>8/4/59</b>					
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>		<b>Crownsville State Hospital, Md.</b> <b>8/4/59</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/10-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Annapolis</b>			
22d. LOCATION (City, town, or county) (State)							
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS <b>Annapolis Md</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 13 '59</b>			
				24b. REGISTRAR'S SIGNATURE 			

MEDICAL CERTIFICATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours  
may be retained by the hospital or attending physician. n: Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

8668

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <i>A A</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>A A</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>416 Fourth St</i>		e. STREET ADDRESS <i>416 Fourth St</i>	
3 NAME OF DECEASED (Type or print) First <i>Laura</i> Middle <i>H.</i> Last <i>Hall</i>		4. DATE OF DEATH Month <i>8</i> - Day <i>19</i> - Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 19-1880</i>
9. AGE (In years last birthday) <i>79</i> yrs.		10. IF UNDER 1 YEAR Months <i>7</i> Days <i>5</i> Hours <i>A</i>	11. IF UNDER 24 HRS Months <i>7</i> Days <i>5</i> Hours <i>A</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Henry Carey</i>		14. MOTHER'S MAIDEN NAME <i>Emily Benson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO <i>-</i>	
17. INFORMANT <i>Earl J. Hall</i>		Address <i>(2)</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio-sclerotic Heart Disease</i> DUE TO <i>420.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio-sclerosis generalis</i> DUE TO <i>2 months</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <i>a. m.</i> Month <i>19</i> Day <i>19</i> Year <i>1959</i> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/10/59</i> to <i>8/19/59</i> that I last saw the deceased alive on <i>8/18/59</i> and that death occurred at <i>10:30</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James R. Martin</i>		DATE SIGNED <i>8/19/59</i>	
PHYSICIAN'S NAME (Type) <i>JAMES R. MARTIN</i>		ADDRESS (Street, city or town, state) <i>6 SHAW ST. ANNAPOLIS, MD.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8-21-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor Sons</i>		24a. REC'D BY REGISTRAR <i>AUG 21 '59</i>	
ADDRESS <i>Annapolis Md</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Brown</i>	

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

1900



8708

## CERTIFICATE OF DEATH

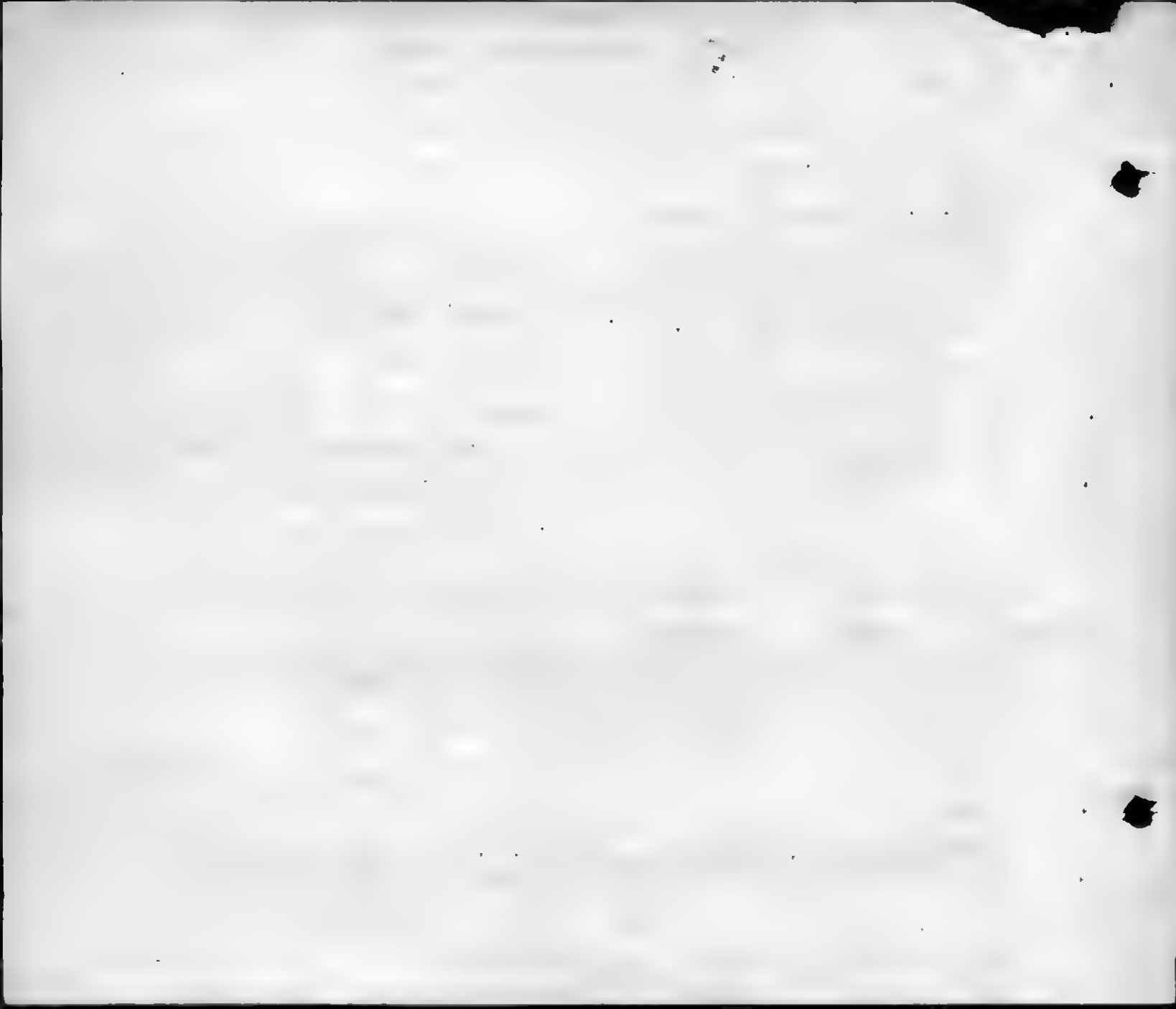
Reg. Dist. No.

27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade, Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Meade Heights, Ft Geo G Meade, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				d. STREET ADDRESS <u>1601 F Annapolis Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First <u>Lucie</u> Middle <u>Jane</u> Last <u>Hall</u>		4. DATE OF DEATH		Month <u>August</u> Day <u>15</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 23, 1923</u>		9. AGE (In years last birthday) <u>36</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Goodwin</u>				14. MOTHER'S MAIDEN NAME <u>Marie Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>385-12-6469</u>		17. INFORMANT <u>Husband, John Hall, 1601 Annapolis Rd, Ft Geo G</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary congestion and edema</u>							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
(b) <u>Pulmonary fibrosis, apex, upper lobe, rt lung</u>							
DUE TO							
(c) <u>Pulmonary Tuberculosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>DOA 0900, 15 August 1959</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Malcolm H. Bloch</u>				ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>17 August 1959</u>			
PHYSICIAN'S NAME (Type) <u>MALCOLM H. BLOCH</u>				U. S. ARMY HOSPITAL, Ft Geo G Meade, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/17/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Ypsilante, Mich.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. C. Wilson</u>				ADDRESS <u>1000 Brantley Ave</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 8 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Glenn R. ...</u>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8665

CERTIFICATE OF DEATH

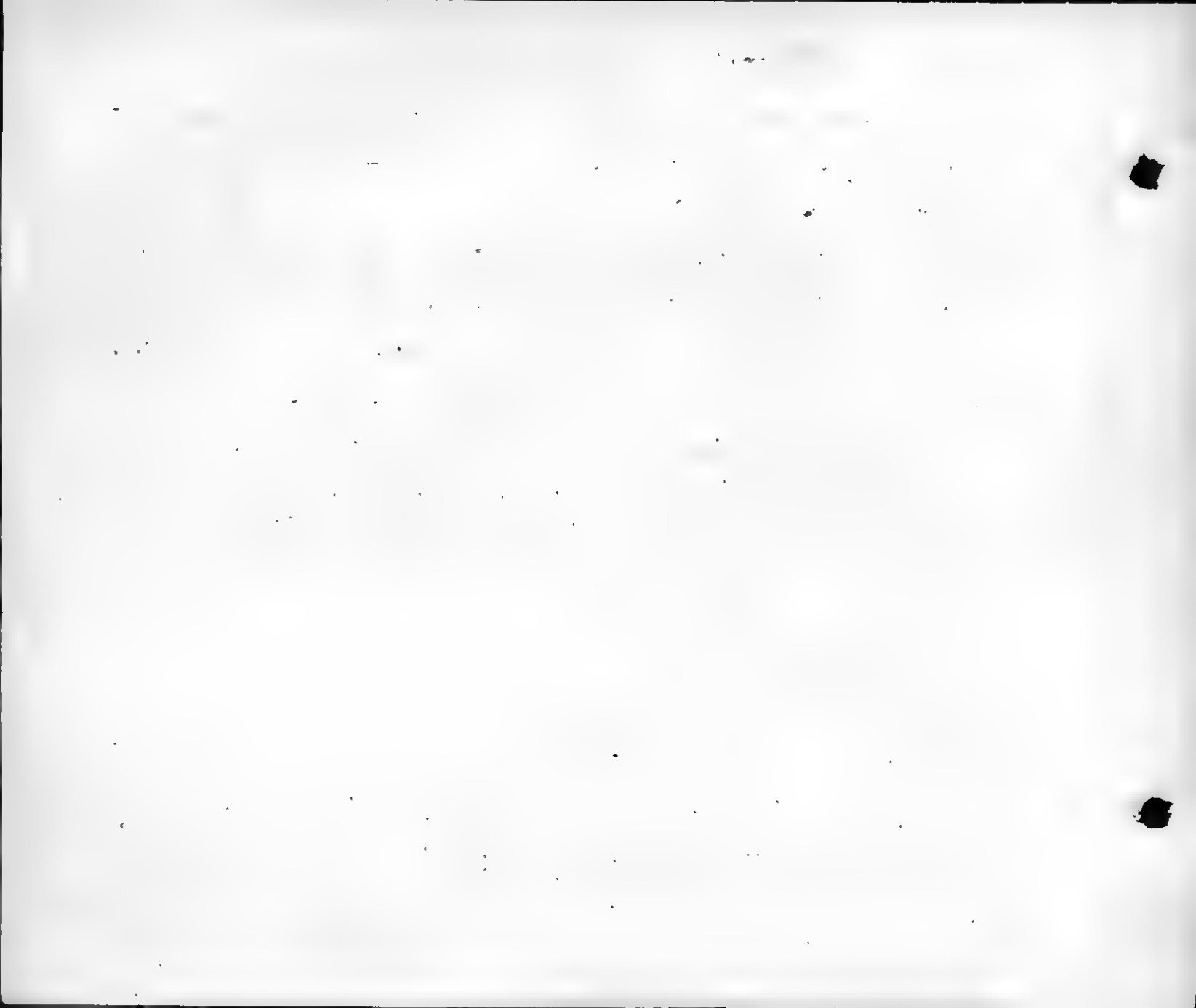
08657

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>1 1/2 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>ANN</b> Last <b>HARDESTY</b>		4. DATE OF DEATH Month <b>August</b> Day <b>12</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 4, 1887</b>
9. AGE (In years lost birthday) <b>71 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Richard Albert Walker</b>		14. MOTHER'S MAIDEN NAME <b>Sallie H. Coale</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-28-8804</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of head of femoral artery, metastases</b> DUE TO (b) <b>at least 6 months</b> DUE TO (c) <b>metastases</b>		18. INTERVAL BETWEEN ONSET AND DEATH <b>at least 6 months</b>	
PART II. OTHER SIGNIF. CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 1959</b> to <b>Aug 12, 1959</b> , that I last saw the deceased alive on <b>Aug 11, 1959</b> , and that death occurred at <b>8:30 AM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Willard F. Smith</b> M.D.		ADDRESS (Street, city or town, state) <b>Shady Side, Md.</b>	
PHYSICIAN'S NAME (Type) <b>WILLARD F. SMITH, MD</b>		DATE SIGNED <b>8/12/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug 14 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Friendship</b>	22d. LOCATION (City, town, or county) (State) <b>Friendship Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Benned Hardisty</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 17 '59</b>	
ADDRESS <b>Salisbury Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Smith</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.





8709

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis RFD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cape St. Claire</b>		d. STREET ADDRESS <b>Cape St. Claire Rt. 4 Box 237</b>	
3. NAME OF DECEASED (Type or print) <b>James W. HARRISON</b>		4. DATE OF DEATH Month <b>8</b> Day <b>18</b> Year <b>1959</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-16-06</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fruit &amp; Produce Broker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Emp.</b>	
11. BIRTHPLACE (State or foreign country) <b>Woodbridge, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James O. Harrison</b>		14. MOTHER'S MAIDEN NAME <b>Julia Stipley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mrs. Mildred M. Harrison</b>		Address <b>5 1/2 W. 4th</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction with heart failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>coronary thrombosis, progressive</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial asthma - Obesity</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>6 months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7-19-1959</b> to <b>8-18-1959</b> , that I last saw the deceased alive on <b>8-17-1959</b> , and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bertrand C. R. Gau</b>		ADDRESS (Street, city or town, state) <b>River Bay Road - Cape St. Claire</b>	
PHYSICIAN'S NAME (Type) <b>Bertrand C. R. GAU</b>		DATE SIGNED <b>8/18/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>20 Aug 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glenn Haven Ceme</b>		22d. LOCATION (City, town, or county) (State) <b>Glenn Burnie, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. P. Stenington</b>		ADDRESS <b>1500 Bunnell St</b>	
24a. REC'D BY REGISTRAR <b>DATE AUG 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8710 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08659

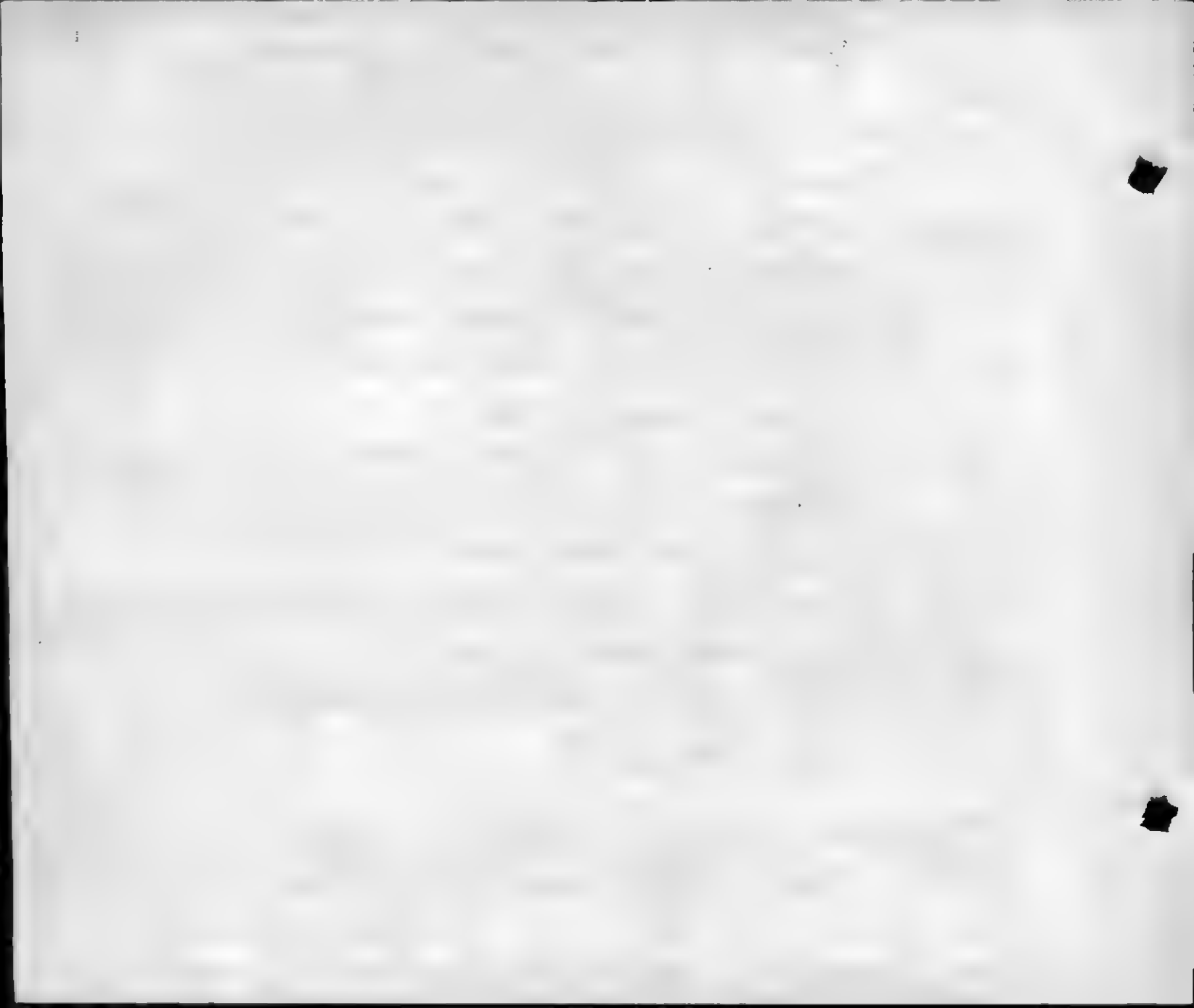
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAND BEACH</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAND BEACH</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HAROLD</u> Middle <u>L.</u> Last <u>HART</u>				4. DATE OF DEATH Month <u>8</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 23, 1905</u>	9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STORE OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STORE KEEPER</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>L.C. Hart</u>				14. MOTHER'S MAIDEN NAME <u>Edna L. Heberline</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>WWII</u>		17. INFORMANT <u>MARY C. Hart</u> Address <u>#2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>circumstances beyond</u> <u>161X</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>	Month, Day, Year <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. L. Wharff</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Wharff</u>		DATE SIGNED <u>8/21/59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)	
<u>BURIAL</u>	<u>8-24-59</u>	<u>UNION CEMETERY</u>		<u>Rockville</u>		<u>Mo.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Geyer + Sons</u>		ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>	

MEDICAL CERTIFICATION

TO DEPUTY N. L. EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

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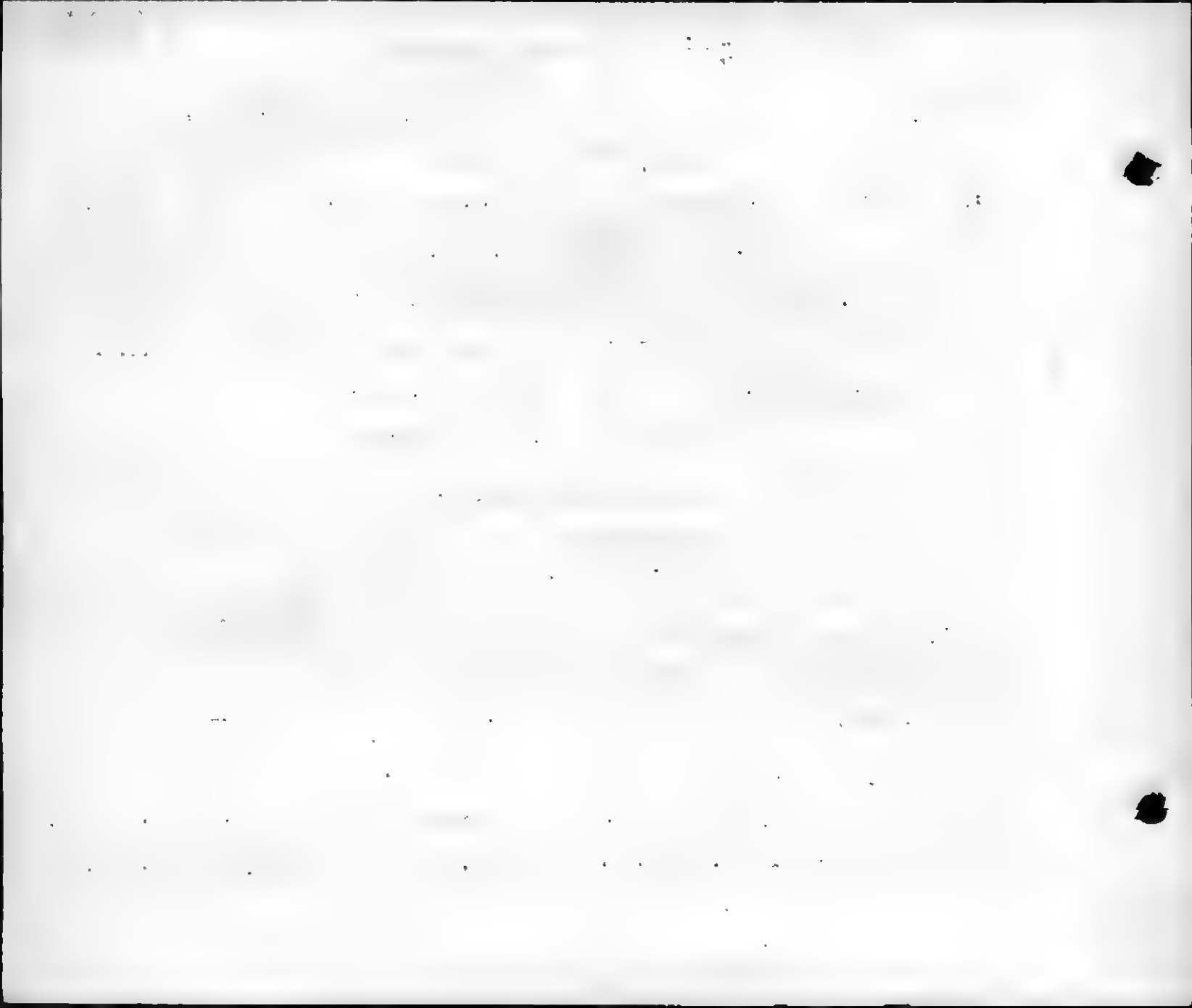
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08660

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>1 year 8 mo. 25 days</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton</b>		d. STREET ADDRESS <b>Route 1, Box 275</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3 NAME OF DECEASED (Type or print) First <b>Thomas</b>		Middle <b>Clifton</b>		Last <b>Hawkins</b>		4. DATE OF DEATH Month <b>8</b>		Day <b>7</b>		Year <b>1959</b>													
5. SEX <b>Male</b>		6 COLOR OR RACE <b>Negro</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>January 22, 1879</b>		9. AGE (In years last birthday) yrs. <b>80</b>		IF UNDER 1 YEAR Months <b>8</b>		Days <b>7</b>		IF UNDER 24 HRS. Hours <b>1959</b>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>											
13. FATHER'S NAME <b>Thomas Jefferson Hawkins</b>						14. MOTHER'S MAIDEN NAME <b>Nettie Kerrick</b>																	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO <b>None</b>				INFORMANT <b>Hospital Records</b>				Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, Acute</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized &amp; Cerebral Arteriosclerosis</b>														INTERVAL BETWEEN ONSET AND DEATH									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Uremia and</b> <b>Dry Gangrene of right foot - Amputation of left foot - Decubitus Ulcers</b>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>				20c. TIME OF INJURY Month, Day, Year Hour a m. <b>-----</b> 19 p. m. <b>-----</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>11/12</b> , 19 <b>57</b> , to <b>8/7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/7</b> , 19 <b>59</b> , and that death occurred at <b>4:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>8/7/59</b>																							
ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i>				M.D. <b>Lionel McHenry Mapp, M. D.</b>				Crownsville State Hospital, Md.				8/7/59											
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>				Crownsville State Hospital, Md.				8/7/59															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>8-9-59</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery, B. Md.</b>				22d. LOCATION (City, town, or county) (State)											
23. FUNERAL DIRECTOR'S SIGNATURE <i>Myrtle K. Rollins</i>				ADDRESS <b>4339 Hunt Cir</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 10 '59</b>				24b. REGISTRAR'S SIGNATURE <i>Clinton S. Harris</i>											



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**8667 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

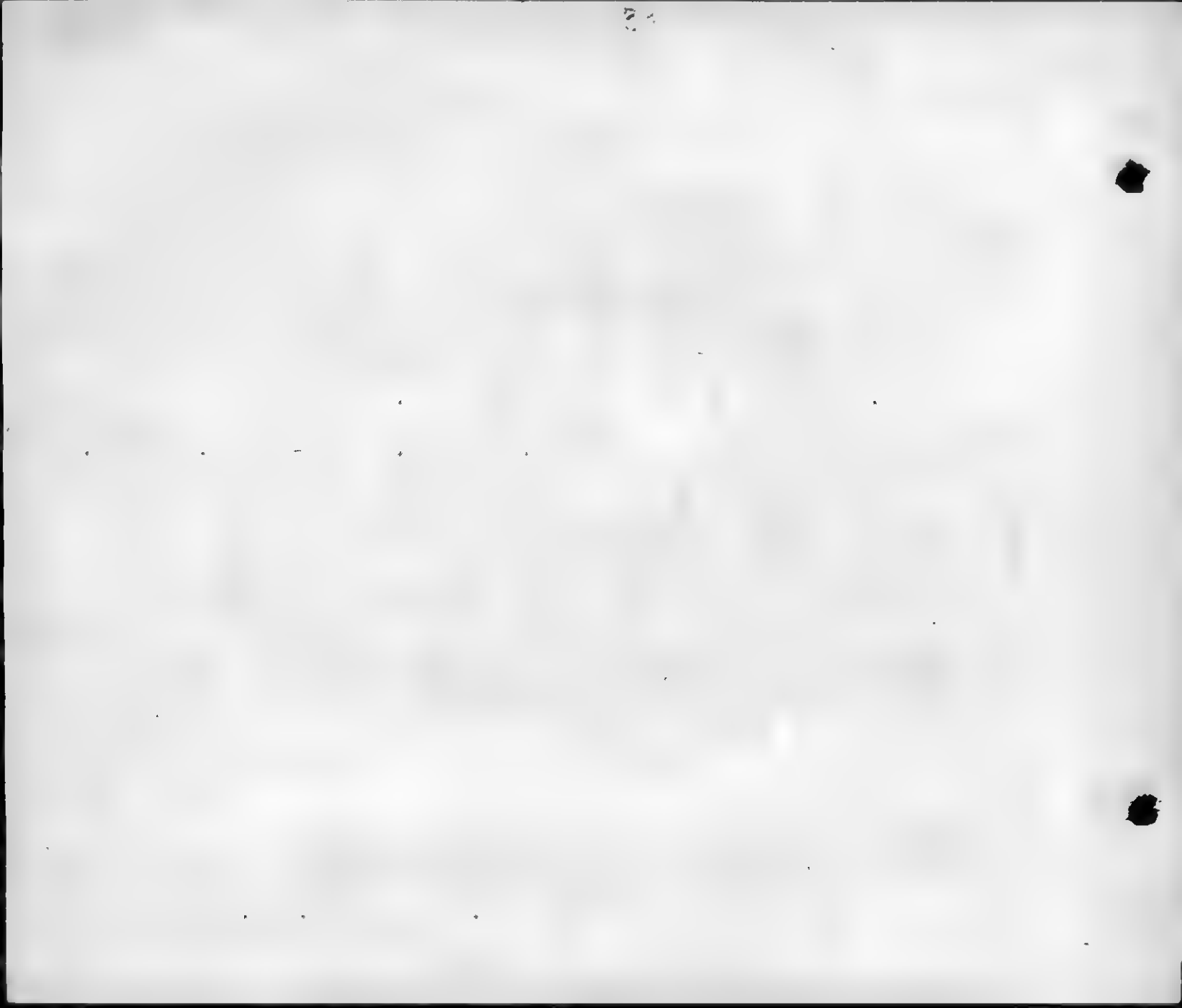
08661

Reg. Dist. No.

**FOR STATE HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <b>A.A.CO.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS-</b> c. LENGTH OF STAY IN 1b <b>6 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ANNE ARUNDEL General L.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MD</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville - Maryland.</b> d. STREET ADDRESS <b>1166 St. Agnes Lane</b> e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John C Hensler</b>	4. DATE OF DEATH Month <b>8</b> Day <b>16</b> Year <b>1959</b>	5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-9-42</b>	9. AGE (In years last birthday) <b>17 yrs</b>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Clifton P. Hensler</b>		14. MOTHER'S MAIDEN NAME <b>Mildred M. Boblitz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Mr. Clifton P. Hensler-1166 St. Agnes La.</b>		Address <b>Catonsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dislocation Cervical Vertebra C3-C4</b> DUE TO <b>Fracture of skull</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture of skull</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Subject dove into shallow water</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>1</b> p.m. <b>8/11</b> 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Chesapeake Bay</b>	20f. (City or town) (County) (State) <b>Allee MD</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>E. L. Lohr</b> NAME (Type) <b>E. L. Lohr</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>8/16/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/19/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Pickens 944-17</b>		24a. REC'D BY REGISTRAR <b>AUG 19 59</b>	24b. REGISTRAR'S SIGNATURE <b>Wm. J. Pickens</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director or, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





8712

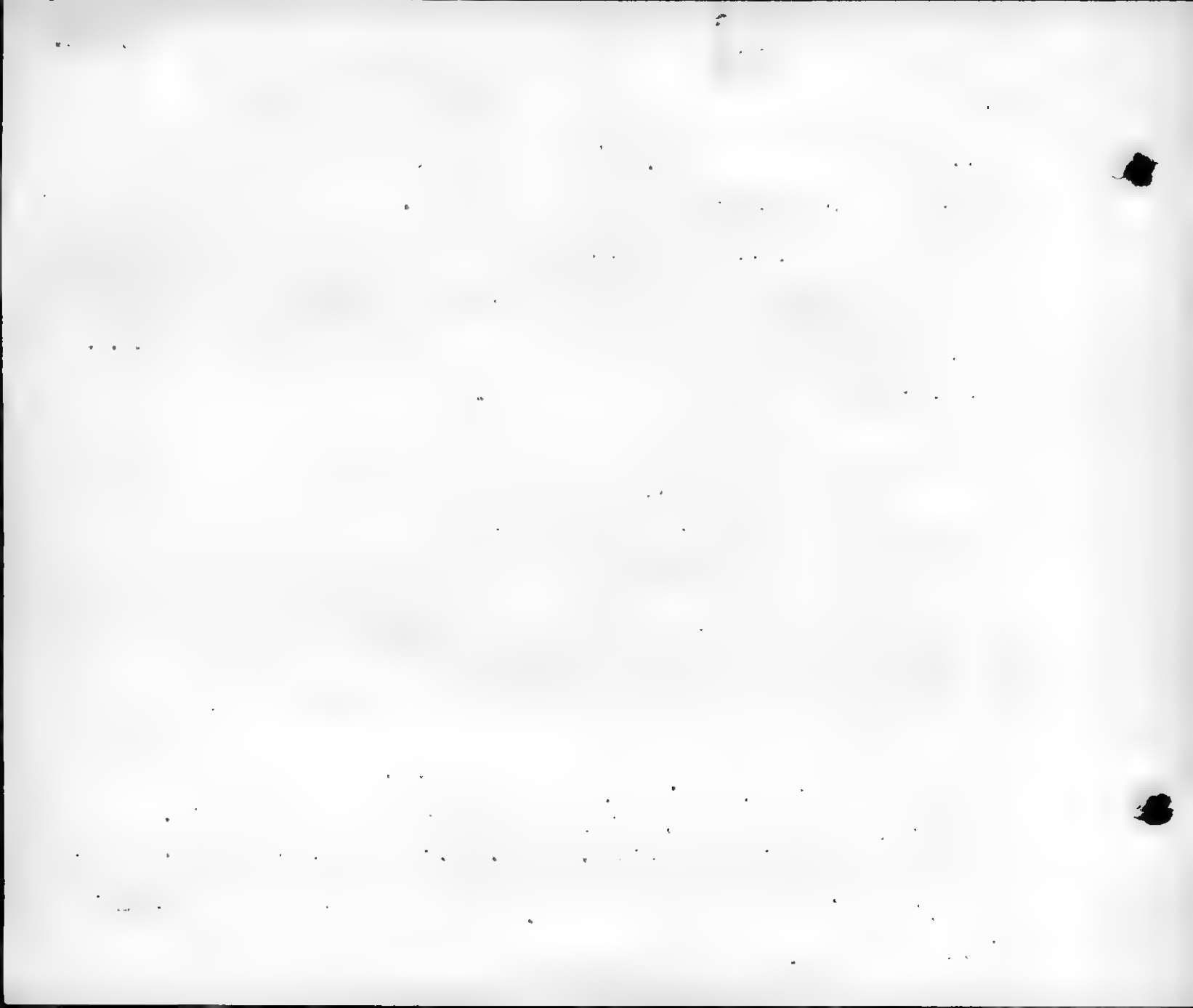
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>21 years 9mo. 24 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>431 Middle Alley</b>									
3. NAME OF DECEASED (Type or print)		First <b>Martha</b>		Middle <b>Washington</b>		Last <b>Hill</b>		4. DATE OF DEATH Month <b>8</b>		Day <b>30</b>		Year <b>19 59</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 22, 1896</b>		9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months <b>63</b>		IF UNDER 24 HRS Days <b>63</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James Hill</b>						14. MOTHER'S MAIDEN NAME <b>Sarah Matthews</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT <b>Hospital Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dehydration &amp; Inanition</b> DUE TO <b>Cerebrovascular Accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Hypertensive Cardiovascular Disease</b> INTERVAL BETWEEN ONSET AND DEATH													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Right Hemiplegia - Decubitus Ulcers</b>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -----									
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>street office bldg.</b>		20f. (City or town) -----		(County) -----		(State) -----	
21. I certify that I attended the deceased from <b>11/6</b> 19 <b>37</b> , to <b>8/30</b> 19 <b>59</b> , that I last saw the deceased alive on <b>8/30</b> 19 <b>59</b> , and that death occurred at <b>6:10 A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>8/31/59</b> ACTUAL SIGNATURE <b>Lionel McHenry Mapp, M. D.</b> M.D. <b>Crownsville State Hospital, Md.</b> <b>8/31/59</b> PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b> <b>Crownsville State Hospital, Md.</b> <b>8/31/59</b>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>9-2-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. MORIAH</b>				22d. LOCATION (City, town, or county) <b>Wheaton, Co., Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks III 24 N. All Saint ST.</b>						ADDRESS <b>Frederick, Md</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton &amp; Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8713

## CERTIFICATE OF DEATH

08663

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LOMBARDEE BEACH</u>				c. LENGTH OF STAY IN 1b <u>5 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Route 1 Box 257, J. J. J. P.O. 110</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LOMBARDEE CIRCLE</u>				d. STREET ADDRESS <u>1 Lombard Circle</u>		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARIE</u> <u>HIRES</u>				4. DATE OF DEATH Month Day Year <u>AUG</u> <u>21</u> <u>19 59</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 15, 1886</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>HENRY PLITT</u>				14. MOTHER'S MAIDEN NAME <u>MARIE PETTE</u> <u>MA. P. W. CLARK</u> <u>BEATHA SCHULTZ</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>MA. P. W. CLARK</u>		Address <u>ADDRESS - SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> <u>4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN</u> , 19 <u>59</u> , to <u>AUG. 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>AUG. 21</u> , 19 <u>59</u> , and that death occurred at <u>1:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>8471 Ft. Smallwood Road</u> <u>8/21/59</u> ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D. <u>PASADENA, MD.</u> PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>							
22a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-24-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore-Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Muller Inc.</u>				ADDRESS <u>2431-35 E. Oliver St.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 24 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Log # 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

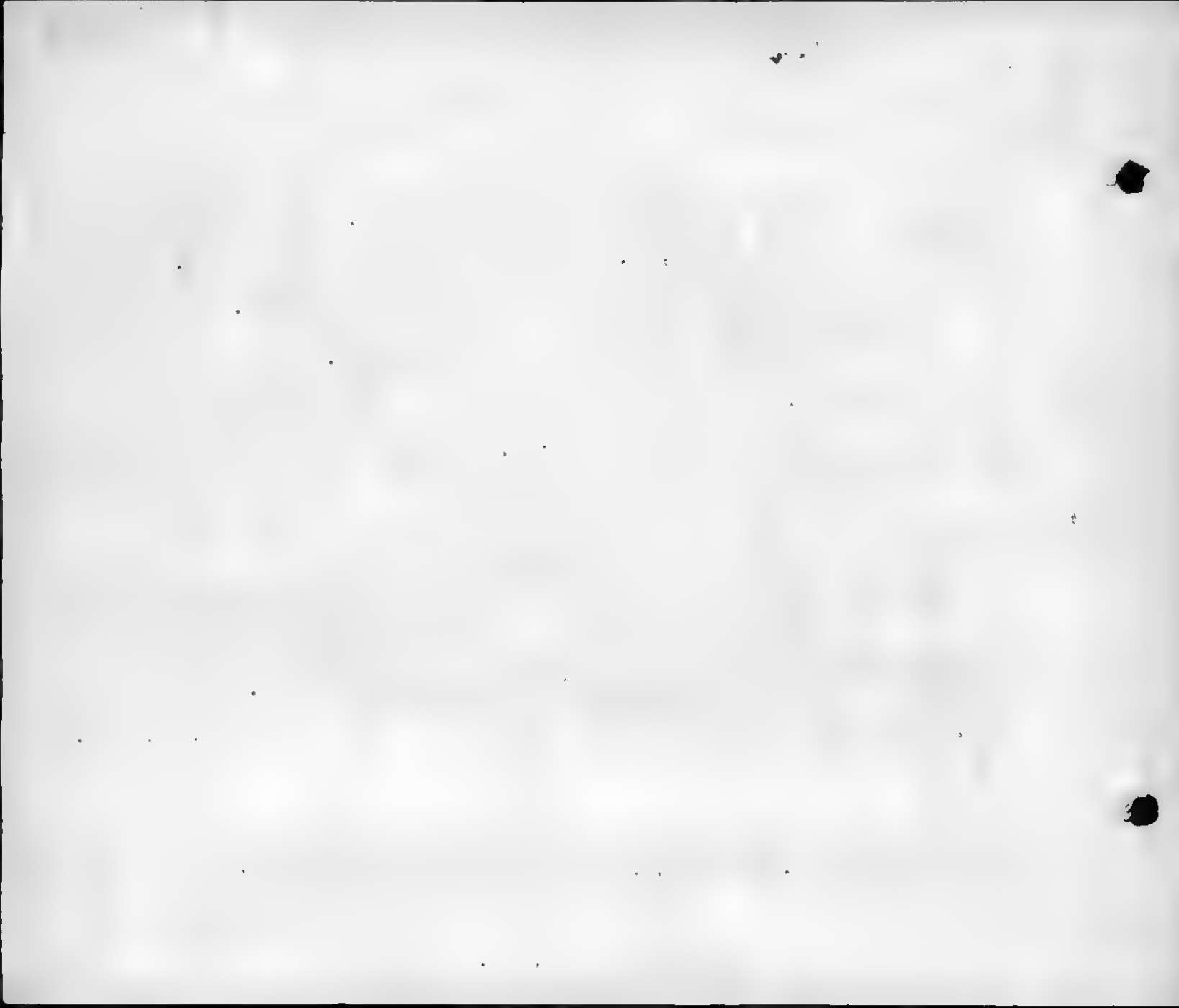
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BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8714 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08664

Reg. Dist No

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Florida</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>Few instants</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Stoney Creek, Lombardee Beach</u>		d. STREET ADDRESS <u>1202 Berwyn Rd., Dover Shores</u>	
3. NAME OF DECEASED (Type or print) <u>James David Hoffman, Jr.</u>		4. DATE OF DEATH Month <u>August</u> Day <u>3rd.</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/19/56</u>
9. AGE (In years last birthday) <u>2y11 m.</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Hoffman, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Iris Mary Cawkwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mrs. Doris Cawkwell (Maternal grandmother)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> <u>29.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Apparently fell in the water from the Pier. (5 feet deep)</u>	
20c. TIME OF INJURY Month, Day, Year <u>5.30</u> a.m. <u>8/3/59</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Stoney Creek</u>		20f. (City or town) (County) (State) <u>Lombardee Beach, A.A. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8/3/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/7/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u>		22d. LOCATION (City, town, or county) (State) <u>Howard County</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirksey</u>		24. REC'D BY REGISTRAR DATE <u>AUG 5 '59</u>	
ADDRESS <u>Glen Burnie, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Knease</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

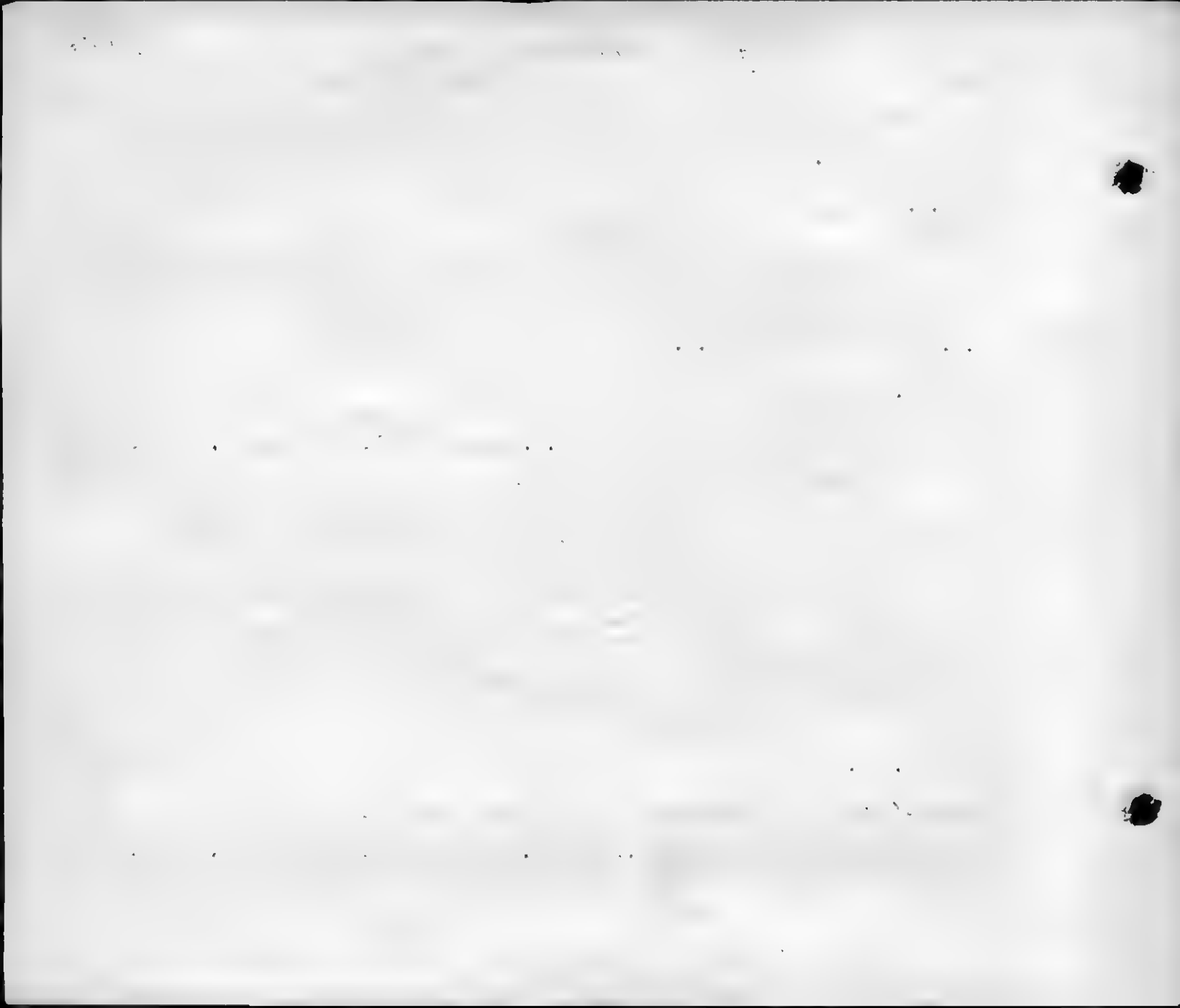
8715

## CERTIFICATE OF DEATH

08665

Reg. Dist. No. 27

1. PLACE OF DEATH • COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft George G. Meade</b>				c. LENGTH OF STAY IN 1b <b>1 yr</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Army Hospital</b>				e. STREET ADDRESS <b>101 Hilltop Rd</b>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>VICTOR</b> Last <b>HORVATH</b>				4. DATE OF DEATH Month <b>August</b> Day <b>2</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cau</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>16 Feb 1916</b>	
9. AGE (In years last birthday) yrs <b>43</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Army Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Louis W. Horvath</b>			
14. MOTHER'S MAIDEN NAME <b>(deceased)</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1942-1959</b>			
16. SOCIAL SECURITY NO. <b>148-09-8784</b>				17. INFORMANT <b>Health Record U.S. Army Hospital, Ft George G. Meade, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion -</b> DUE TO <b>Arteriosclerosis of left anterior descending coronary artery.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>coronary artery.</b> (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <b>D.O.A. 2 Aug 19 59</b> , and that death occurred at <b>2000P M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>Stanley Siegelman</b> M.D. <b>USA Hospital, Ft Meade, Md</b> <b>2 Aug 59</b> PHYSICIAN'S NAME (Type) <b>STANLEY SIEGELMAN, Capt., MC, US. Army Hospital, Ft George G. Meade, Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8-5-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR <b>DATE AUG 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>C. J. ...</b>	





8716

Item 5 811-247 8-31-59 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrills</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Gambrills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.F.D. #1 Higgins Drive</u>		d. STREET ADDRESS <u>R.F.D. #1 Higgins Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Helene Smith Hughey</u>		4. DATE OF DEATH Month Day Year <u>Aug. 23 19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19, 1927</u>
9. AGE (In years last birthday) yrs <u>31</u>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Brewer Maine</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Arthur D. Smith</u>	
14. MOTHER'S MAIDEN NAME <u>Nora Smith</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No None</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Miss Pamela Hughey Same as no. #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Thrombosis.</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Sclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JULY 20, 1959</u> , to <u>August 22, 1959</u> , that I last saw the deceased alive on <u>August 14, 1959</u> , and that death occurred at <u>2:10 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1101 Nor 57 8/24/59</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Felices Greenberg</u>		M.D. <u>1101 Nor 57</u>	
PHYSICIAN'S NAME (Type) <u>Felices Greenberg</u>		<u>Odeaton</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>Aug. 26, 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>		ADDRESS <u>Glen Lurien Rd.</u>	24a. REC'D BY REGISTRAR DATE <u>AUG 27 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8717

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>	
c. LENGTH OF STAY IN b. <u>37 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1 Medora Road</u>		e. STREET ADDRESS <u>#101 Medora Road</u>	
3. NAME OF DECEASED (Type or print) <u>MARGARET M. INWOLD</u>		4. DATE OF DEATH <u>August 5, 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28, 1925</u>
9. AGE (In years last birthday) <u>34</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Stockett</u>		14. MOTHER'S MAIDEN NAME <u>Anna Weyler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Miss Katherine Inwold,</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Cancer of spinal vertebrae</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Aug-1-59</u> <u>10 yrs -</u> <u>15 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1958</u> to <u>Aug 5, 1959</u> , that I last saw the deceased alive on <u>Aug 5, 1959</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas. L. Ball Jr.</u>		ADDRESS (Street, city or town, state) <u>Linthicum Md.</u>	
PHYSICIAN'S NAME (Type) <u>Chas. L. Ball Jr.</u>		DATE SIGNED <u>8/7/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>August 8, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE AUG 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carl S. Frank</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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8669

## CERTIFICATE OF DEATH

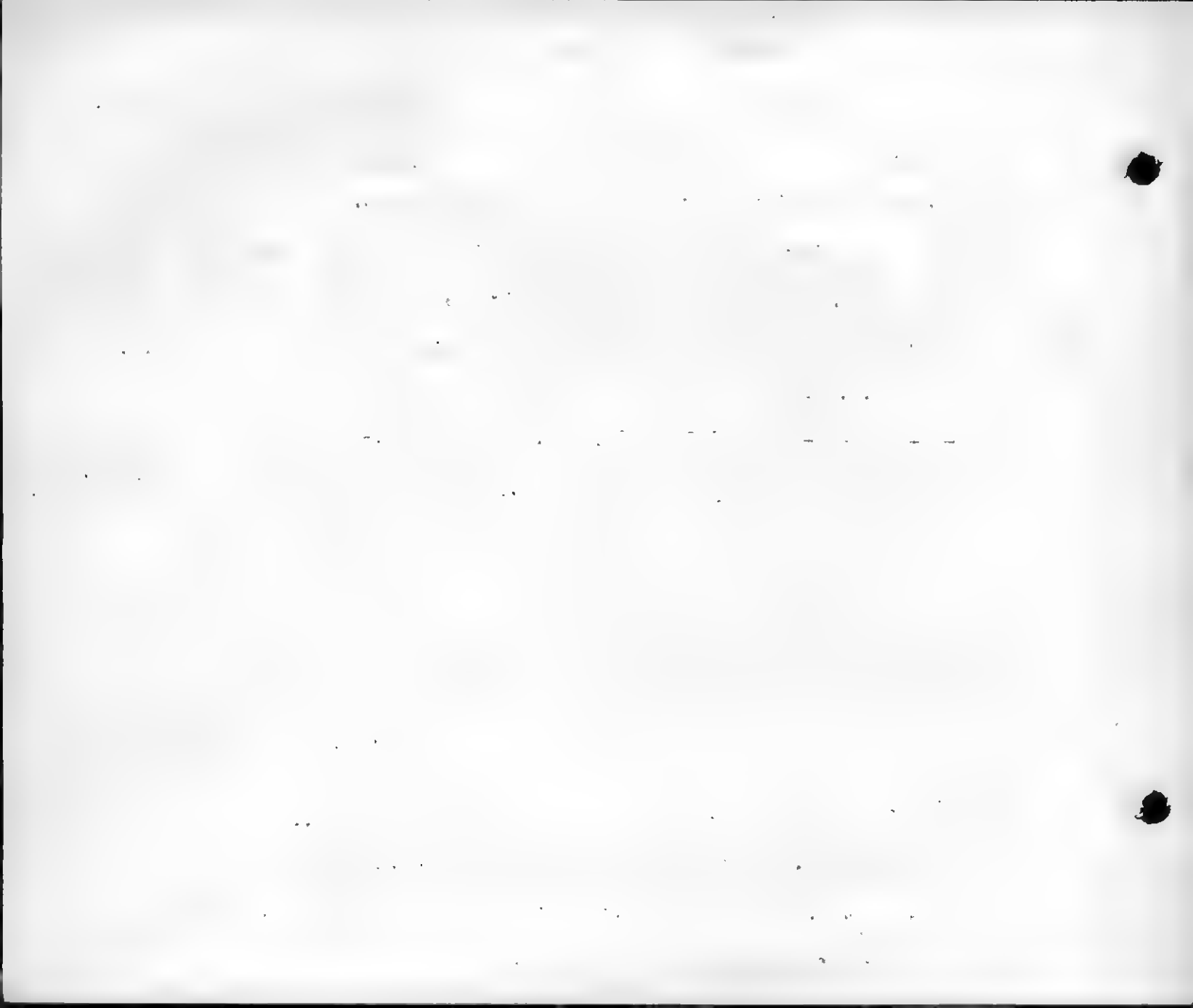
Reg. Dist. No.

08669

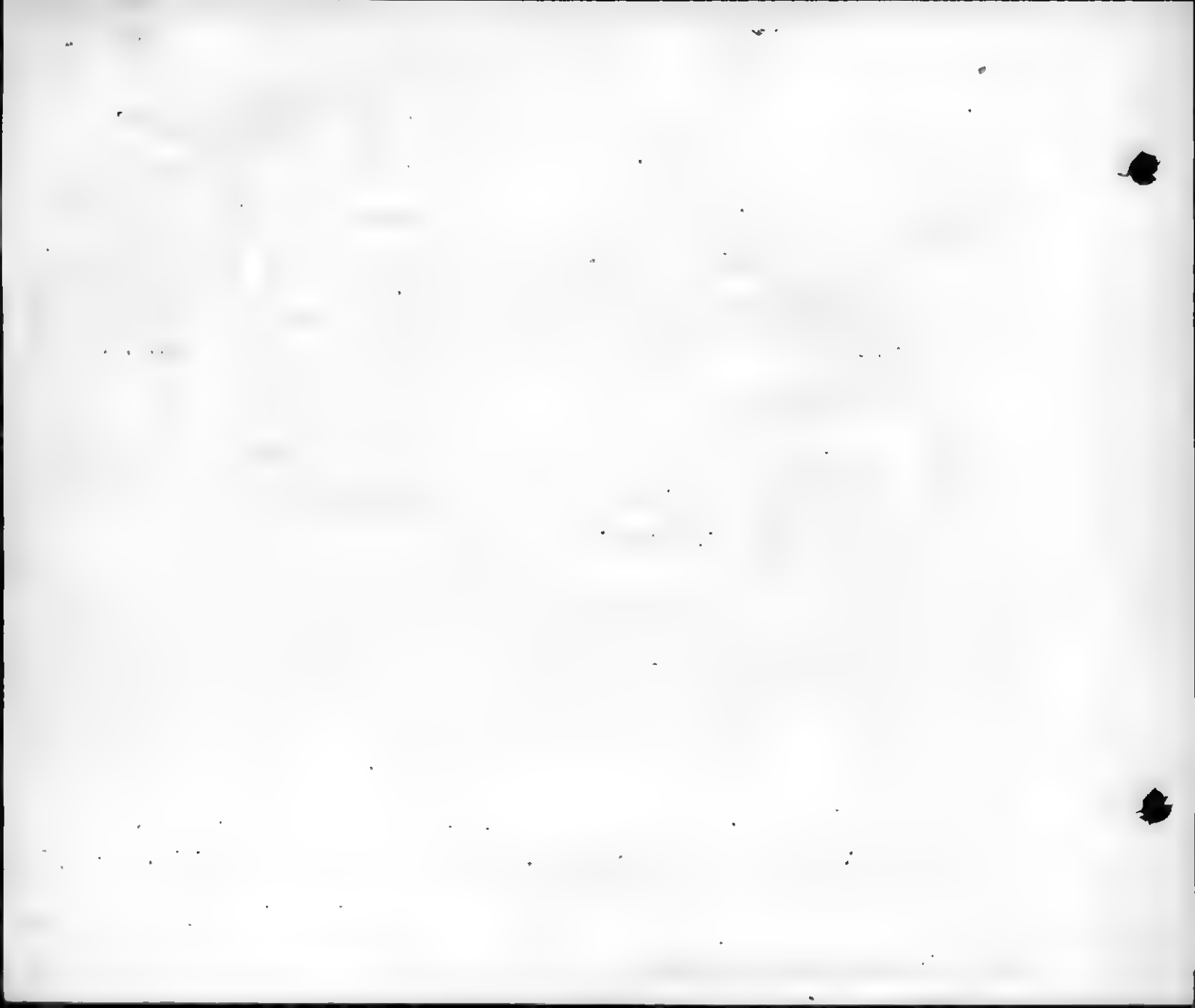
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. STREET ADDRESS <b>1204 West St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Bert</b> Middle <b>JACKSON</b> Last <b>JACKSON</b>		4. DATE OF DEATH Month <b>August</b> Day <b>27</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 10, 1898</b>
9. AGE (In years lost birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months <b>61</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stocks and Bonds</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>J.M. Jackson</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>053 18 4995</b>	
17. INFORMANT <b>Mr. Alvin Jackson- Brother- same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/26</b> , 19 <b>59</b> , to <b>8/26</b> , 19 <b>59</b> , that I lost saw the deceased alive on <b>8/26</b> , 19 <b>59</b> , and that death occurred at <b>3:40 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>121 Cathedral St., Annapolis, Maryland</b> DATE SIGNED <b>8/27/59</b>			
ACTUAL SIGNATURE <b>Richard N. Peeler</b>		PHYSICIAN'S NAME (Type) <b>Richard N. Peeler</b> <b>Annapolis, Maryland</b>	
22a. BURIAL, CREMAT. OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 29, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b> ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 31 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





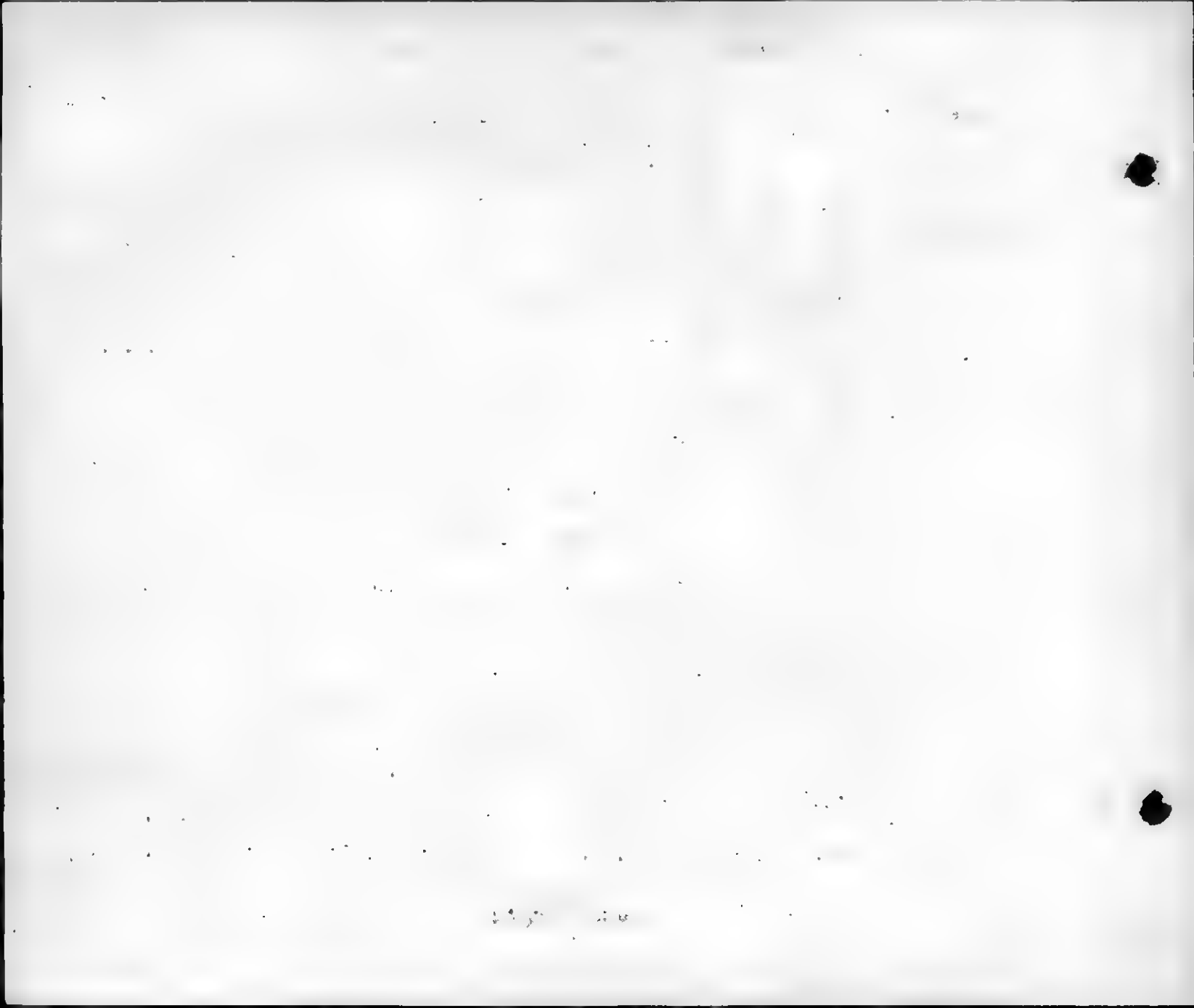




VS A15 (4)  
15M 9/5B

## MEDICAL CERTIFICATION

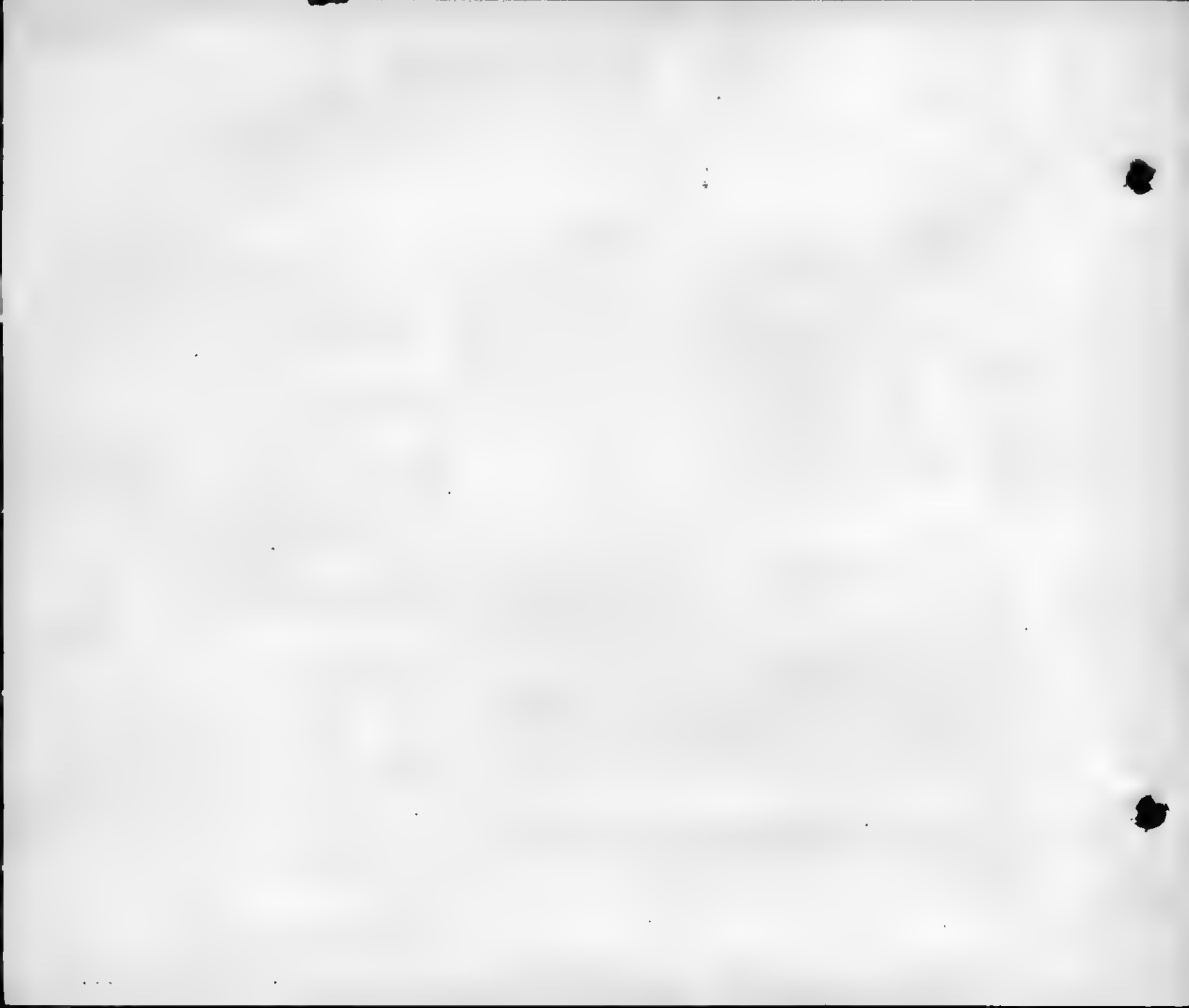
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN IB <b>5 years 2mo. 22 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Unknown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>Unknown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Minnie</b>		Middle <b>Anna</b>		Last <b>Jackson</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH Month <b>8</b> Day <b>23</b> Year <b>19 59</b>	
9. AGE (In years most birthday) <b>68</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cardiovascular Accident</b> DUE TO (c) <b>Arteriosclerotic Hypertension, Cardiovascular Disease</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>-----</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/1</b> 19 <b>54</b> to <b>8/23</b> 19 <b>59</b> , that I last saw the deceased alive on <b>8/23</b> 19 <b>59</b> and that death occurred at <b>6:40P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>8/24/59</b> ACTUAL SIGNATURE <b>Libnel McHenry Mapp</b> M.D. <b>Crownsville State Hospital, Md.</b> <b>8/24/59</b> PHYSICIAN'S NAME (Type) <b>Libnel McHenry Mapp, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/28/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Washington</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. McQuire</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



## 08672

## MEDICAL CERTIFICATION

VS A15 (4)  
15M 10/57



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8671

## CERTIFICATE OF DEATH

08673

Reg. Dist. No.

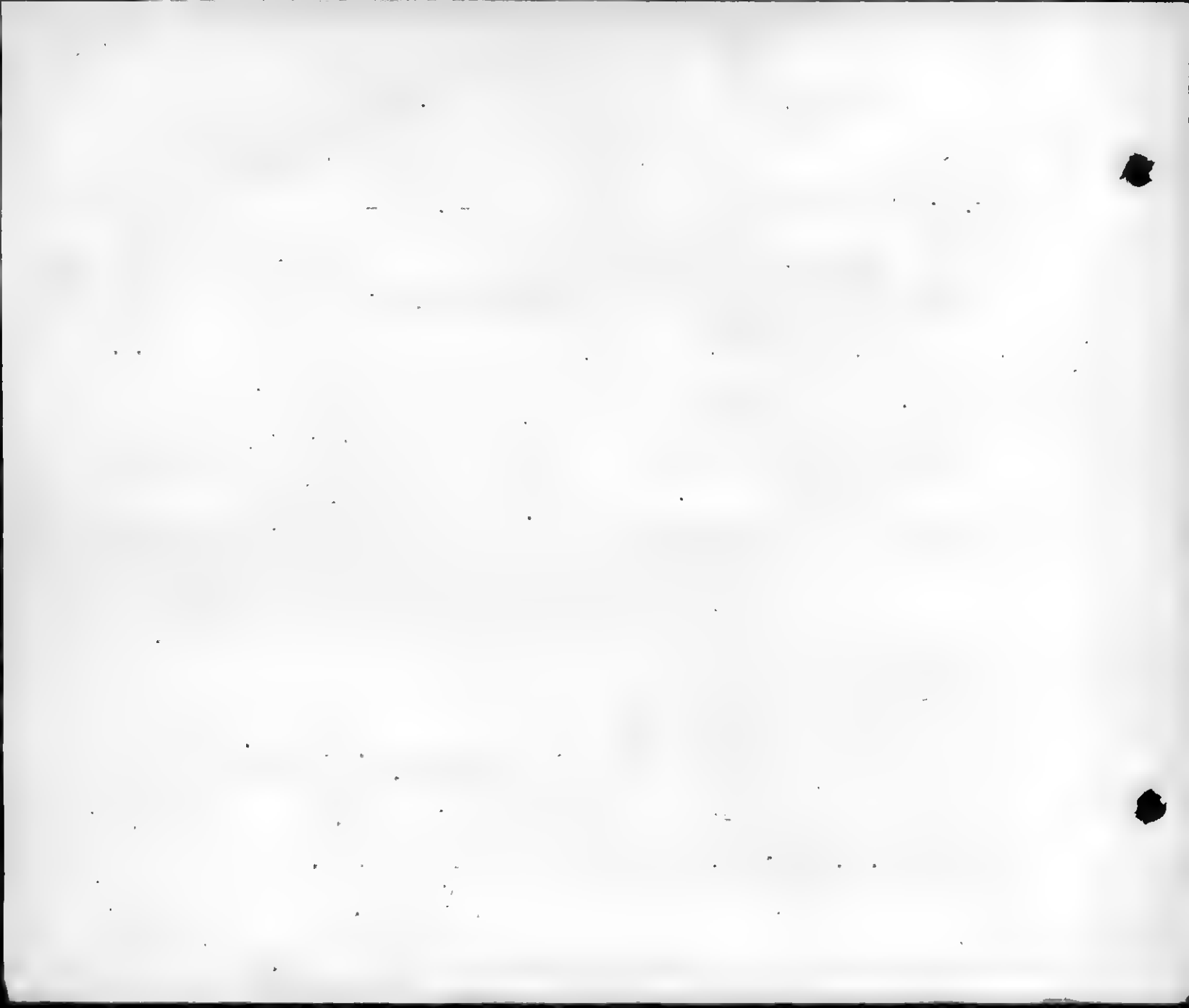
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>9 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Annapolis</b>	
f. STREET ADDRESS <b>Rt-4, Box-2</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>JOHNSON</b> Last <b>JOHNSON</b>		4. DATE OF DEATH Month <b>August</b> Day <b>5</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 13, 1913</b>
9. AGE (In years last birthday) <b>45</b> yrs.		10. IF UNDER 1 YEAR Months <b>45</b> Days <b>45</b> Hours <b>45</b> Min.	11. IF UNDER 24 HRS Months <b>45</b> Days <b>45</b> Hours <b>45</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher A.A.C.B.H.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John R. Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>Chaceice M. Johnson R. 4 B42211111</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>600.0</b> DUE TO <b>Memoria Due to Chronic Pyelonephritis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Chronic Pyelonephritis</b> (c) <b>Chronic Pyelonephritis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 27,</b> 19 <b>59</b> , to <b>Aug. 5,</b> 19 <b>59</b> that I last saw the deceased alive on <b>August 5,</b> 19 <b>59</b> , and that death occurred at <b>9:40 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. L. Richardson</b>		M.D. <b>110 Clay St.,</b> DATE SIGNED <b>8/5/59</b>	
PHYSICIAN'S NAME (Type) <b>R. L. Richardson</b>		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-9-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Broad Neck</b>	22d. LOCATION (City, town, or county) (State) <b>St. Margaret's, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. Hazzett</b>		ADDRESS <b>Annapolis Md</b>	
24a. REC'D BY REGISTRAR <b>AUG 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton A. Thomas</b>	

1

TO HOSPITAL OR FUNERARY PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8720

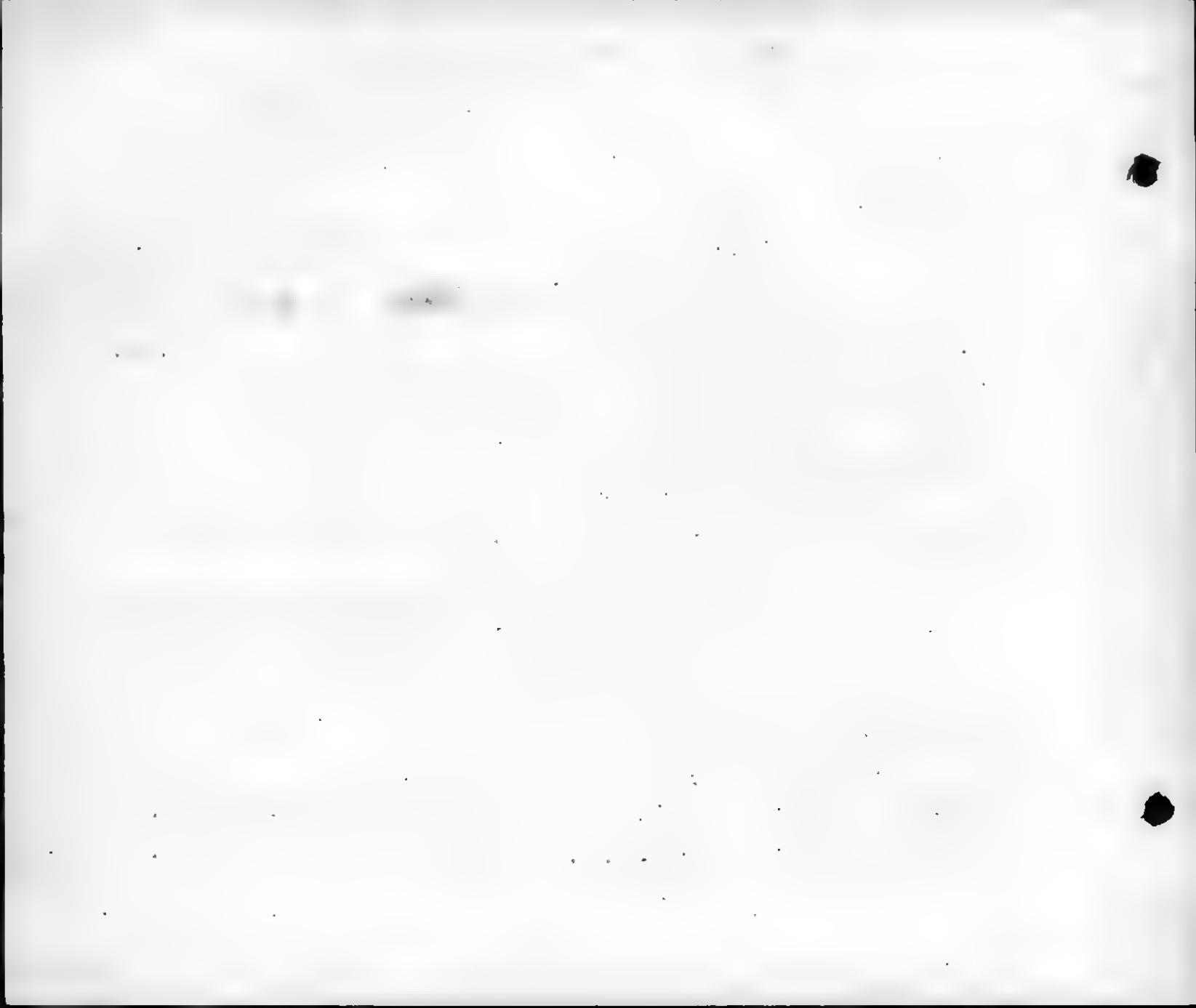
## CERTIFICATE OF DEATH

Reg. Dist. No.

08674

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN lb <u>18 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Queen Annes</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u> d. STREET ADDRESS <u>Unknown</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
<b>3. NAME OF DECEASED</b> (Type or print) <span style="float: right;">First Middle Last</span> <u>Grace Jones</u>		<b>4. DATE OF DEATH</b> Month <u>8</u> Day <u>5</u> Year <u>19 59</u>		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <span style="float: right;">WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></span>		<b>8. DATE OF BIRTH</b> <u>May 6, 1916</u>		<b>9. AGE</b> (In years last birthday) <u>43</u> yrs		<b>IF UNDER 1 YEAR</b> Months <u>43</u> Days <u>43</u>		<b>IF UNDER 24 HRS.</b> Hours <u>43</u> Min <u>43</u>							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housework</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-----</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Unknown</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>Mart Jones</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Pierce</u>															
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO</b> <u>Unknown</u>				<b>INFORMANT</b> <u>Hospital Records</u>				Address											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Cerebral Vascular Accident with left hemiplegia</u> DUE TO (c)														INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (a) <u>CNS Syphilis with Epileptiform Convulsions - Decubitus Ulcers</u>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. ACC DENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>				<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>-----</u> p. m. <u>-----</u> 19 <u>59</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>-----</u>				<b>20f. (City or town)</b> <u>-----</u> (County) <u>-----</u> (State) <u>-----</u>			
<b>21. I certify that I attended the deceased from</b> <u>7/17</u> , 19 <u>59</u> , to <u>8/5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/5</u> , 19 <u>59</u> , and that death occurred at <u>7:45</u> A. M. from the causes and on the date stated above.																							
<b>ACTUAL SIGNATURE</b> <u>Lionel McHenry Mapp</u>				<b>ADDRESS</b> (Street, city or town, state) <u>Crownsville State Hospital, Md.</u>				<b>DATE SIGNED</b> <u>8/5/59</u>															
<b>PHYSICIAN'S NAME (Type)</b> <u>Lionel McHenry Mapp, M. D.</u>				<b>ADDRESS</b> <u>Crownsville State Hospital, Md.</u>				<b>DATE SIGNED</b> <u>8/5/59</u>															
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>				<b>22b. DATE THEREOF</b> <u>8/8/59</u>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Borresville</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>Centreville</u> <u>Md</u>											
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Edgar L. Sam Church Hill Md</u> <b>ADDRESS</b>																							
<b>24a. REC'D BY REGISTRAR</b> <u>-----</u>								<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Evans</u>															

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8672

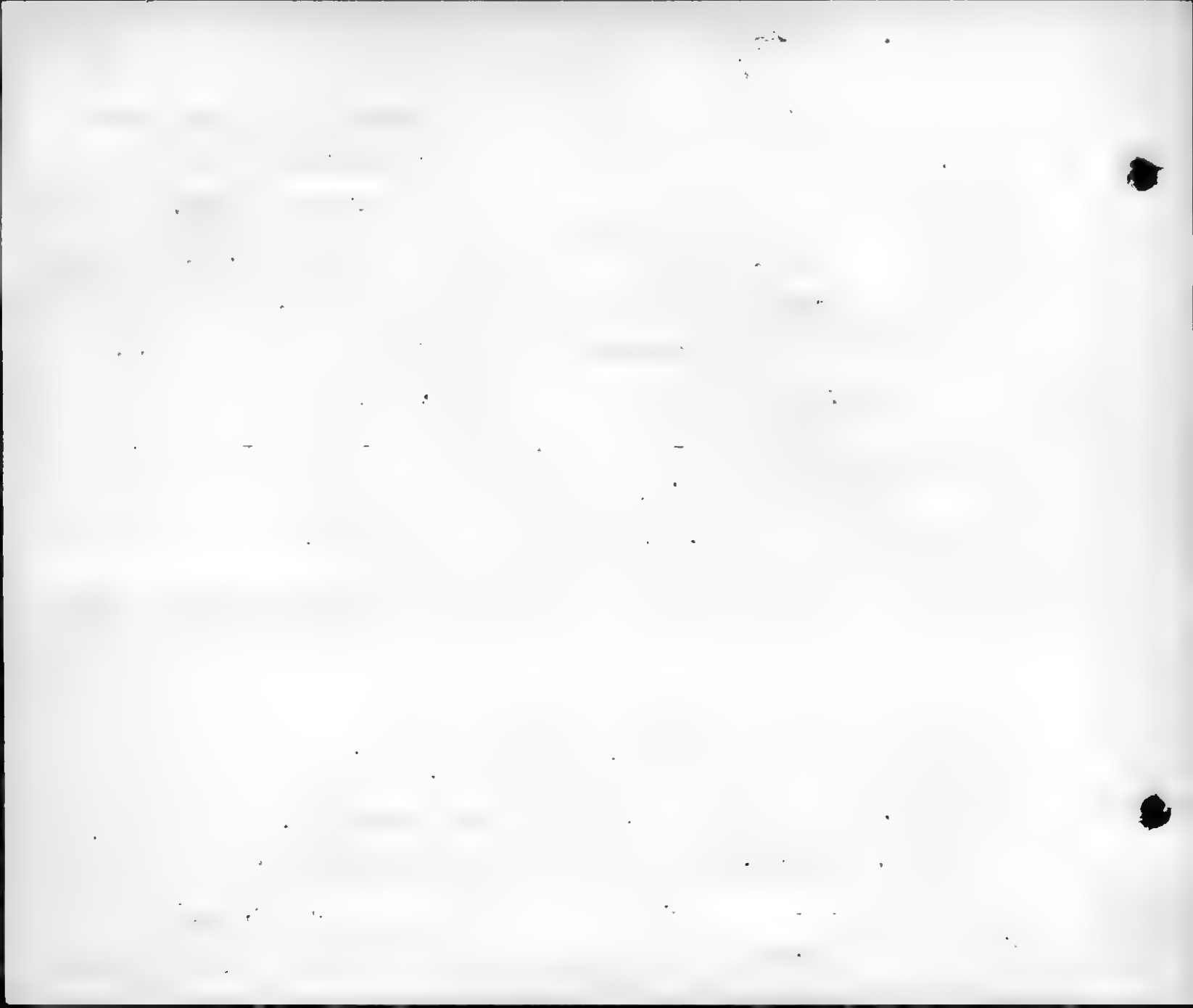
## CERTIFICATE OF DEATH

Reg. Dist. No.

08675

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. STREET ADDRESS <b>1101 Baltimore-Annapolis, Blvd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>JORDAN</b> Last <b>JORDAN</b>		4. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 10, 1905</b>
9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR Months <b>54</b> Days <b>54</b> Hours <b>54</b> Min. <b>54</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Jacob Hillard</b>		14. MOTHER'S MAIDEN NAME <b>Cynthia Wright</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>413-01-6135</b>	
17. INFORMANT <b>Mr. Rolley Jordan- Husband - same as # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Obstructive jaundice</b> <b>157X</b> DUE TO <b>Carcinoma of body of pancreas.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b> <b>6 wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 14, 1959</b> , to <b>Aug 24, 1959</b> , that I last saw the deceased alive on <b>Aug 23, 1959</b> , and that death occurred at <b>12:03 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>121 Cathedral St., Annapolis, Maryland</b> DATE SIGNED <b>8/24/59</b>			
ACTUAL SIGNATURE <b>John C. Hedeman</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. John Hedeman</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-26-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING AND KIRKLEY</b>		24a. REC'D BY REGISTRAR <b>AUG 27 '59</b>	
ADDRESS <b>Glen Burnie, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

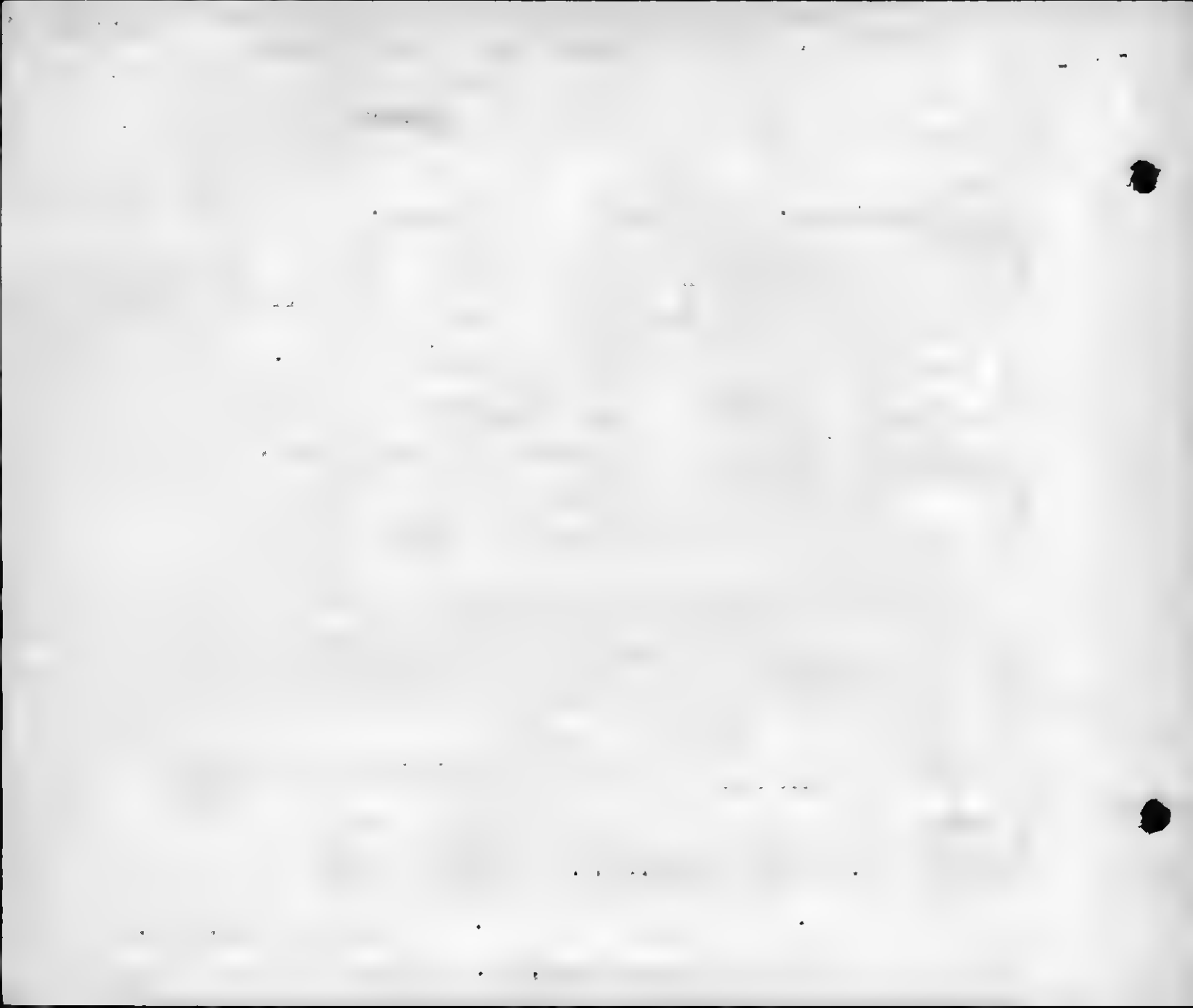
8721

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08676

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Philadelphia</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glen Brook Rd., Glen Burnie,</b>				d. STREET ADDRESS <b>2941 S. Smedley Street</b>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>LACHER</b> Last <b>LACHER</b>				4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8 July 1991</b>	9. AGE (In years for birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Phila. Mint</b>		11. BIRTHPLACE (State or foreign country) <b>Phoenixville, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MICHAEL LACHER</b>				14. MOTHER'S MAIDEN NAME <b>DOROTHY (unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Mrs. Margaret Lacher, Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatic heart disease with involvement of aortic valve</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>a. m.</b> <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>W. Bradley King, Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8/26/59</b>			
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 29/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Delaware Co., Pa.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Roberts Funeral Home</b>				24a. REC'D BY REGISTRAR <b>DATE AUG 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

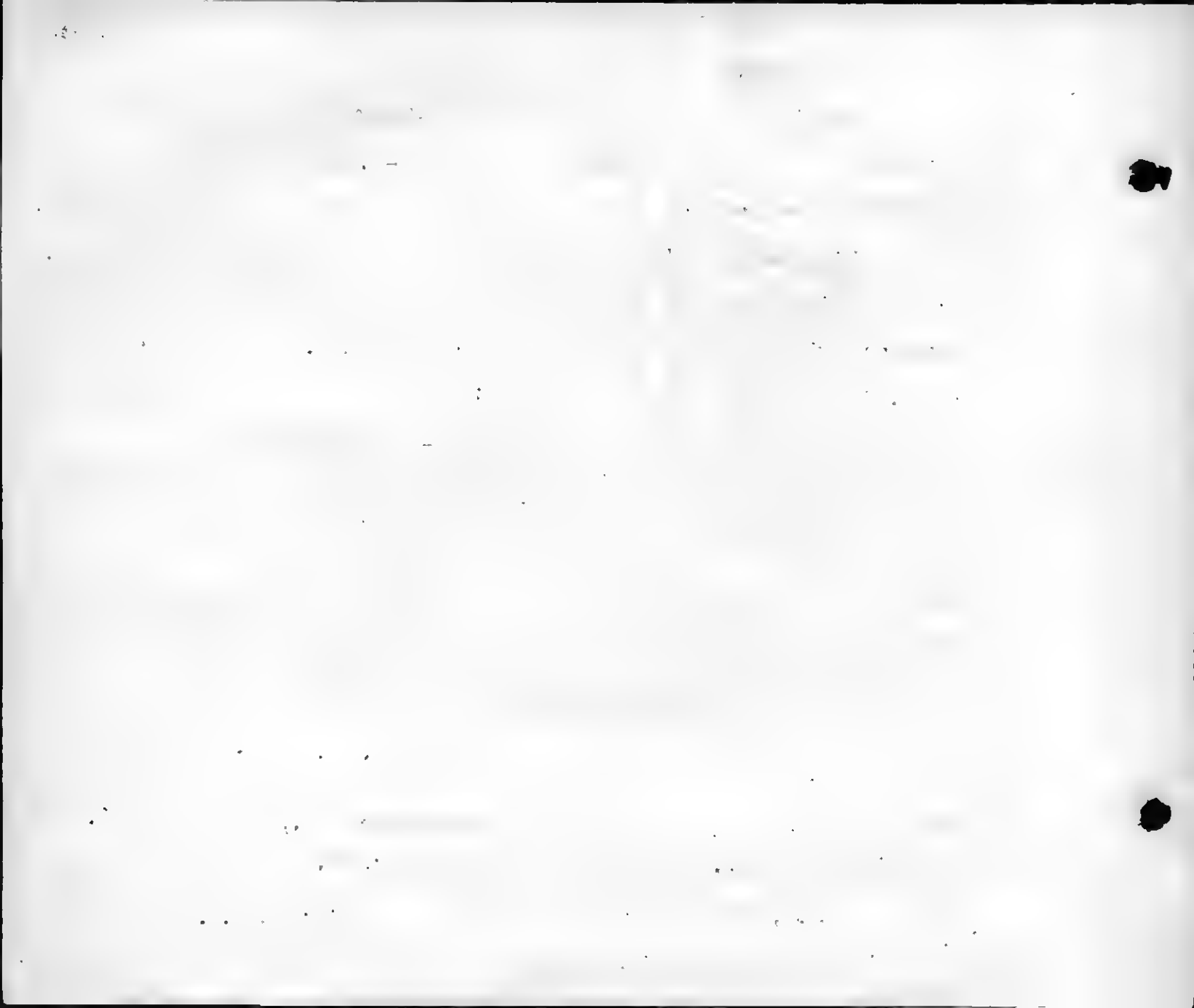


## CERTIFICATE OF DEATH

Reg. Dist. No.

8673

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>10 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. d STREET ADDRESS <b>South River Park</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Katherine</b> Middle <b>V</b> Last <b>LAWMAN</b>				4. DATE OF DEATH Month <b>August</b> Day <b>13</b> Year <b>1959</b>			
5 SEX <b>Female</b>		6 COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 29, 1882</b>	
9 AGE (In years last birthday) <b>77 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11 BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James P. Taylor</b>				14. MOTHER'S MAIDEN NAME <b>Molly Curry</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>no</b>		INFORMANT <b>James Lawman- Son- same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>181.0</b> DUE TO <b>Melaninization</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the Bladder</b> DUE TO <b>192.1</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 9, 1959</b> , to <b>Aug. 13, 1959</b> , that I last saw the deceased alive on <b>August 13, 1959</b> , and that death occurred at <b>1:15 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>98 Cathedral St., Annapolis, Md.</b>							
ACTUAL SIGNATURE <b>Edwin Davis, Jr.</b>		M.D.		DATE SIGNED <b>8/14/59</b>			
PHYSICIAN'S NAME (Type) <b>Edwin Davis, Jr.</b>				<b>Annapolis, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 17, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING FUNERAL HOME</b>				ADDRESS <b>Annapolis, Maryland</b>		24a. REC'D BY REGISTRAR <b>Aug 17 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			



8674

## CERTIFICATE OF DEATH

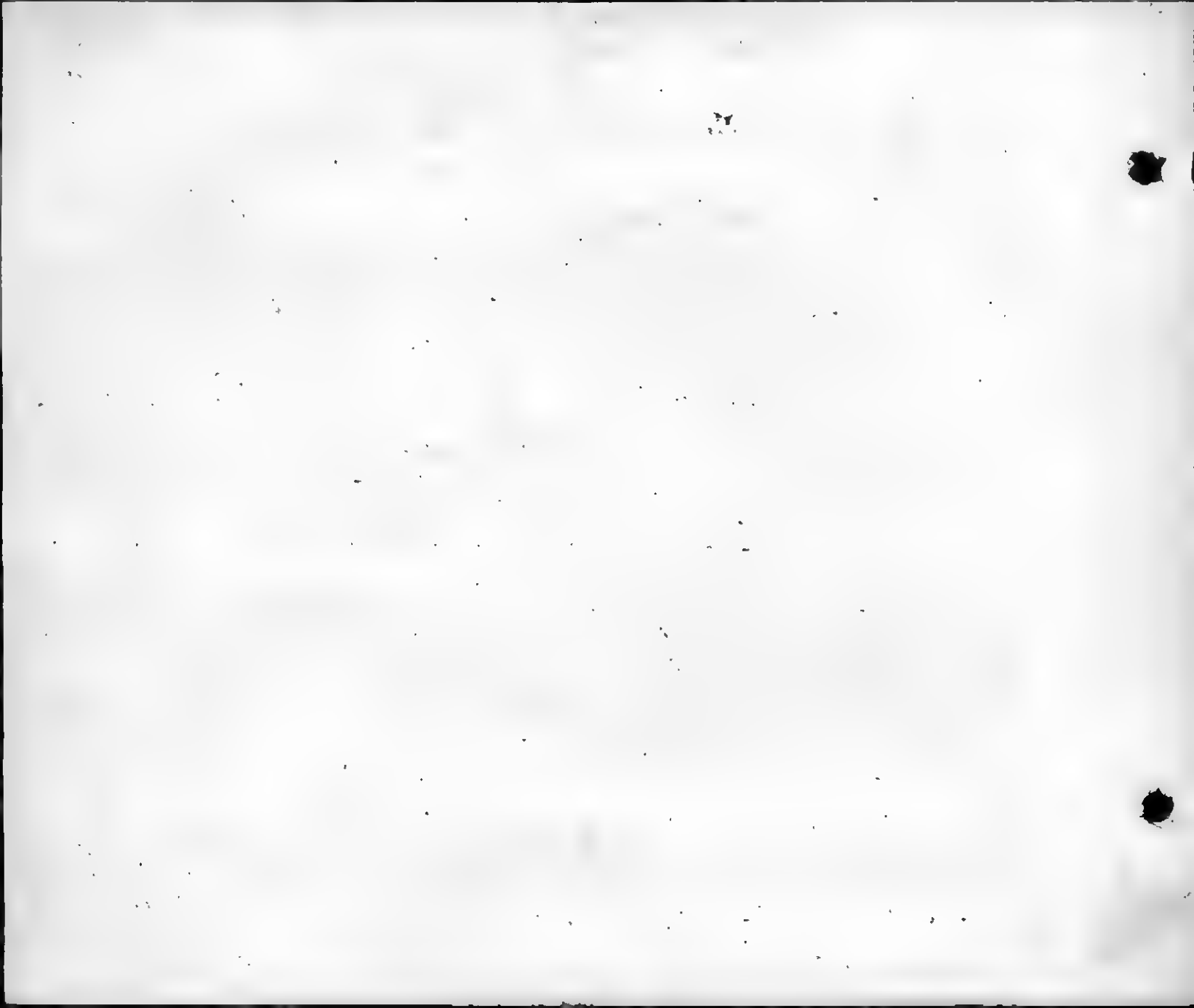
08678

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A. County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>A.A. County</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Armed Forces General Hospital</i>		d. STREET ADDRESS <i>Box 765 Annapolis, Md.</i>	
3. NAME OF DECEASED (Type or print) First <i>Fannie</i> Middle <i>Leonard</i> Last <i>Williams</i>		4. DATE OF DEATH Month <i>8</i> Day <i>1</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-2-1913</i>
9. AGE (In years lost birthday) <i>46</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Alabama</i>
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Moses Williams</i>		14. MOTHER'S MAIDEN NAME <i>Ella Bradley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>1-5-5-5-5-5-5-5-5-5</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Wernia due to</i> DUE TO <i>Acute glomerulonephritis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>10 days</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Secondary anemia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 31, 1959</i> to <i>Aug 1, 1959</i> that I last saw the deceased alive on <i>July 31, 1959</i> and that death occurred at <i>12:00 M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>F. P. Williams</i>		DATE SIGNED <i>8/1/59</i>	
PHYSICIAN'S NAME (Type) <i>William H. Williams</i>		ADDRESS <i>110. 1st St. N. W. Wash. D.C.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>8-9-1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Matthew H. H. Williams</i>		22d. LOCATION (City, town, or county) (State) <i>Ala.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William H. Williams</i>		24a. REC'D BY REGISTRAR <i>AUG 4 '59</i>	
ADDRESS <i>110. 1st St. N. W. Wash. D.C.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur H. Williams</i>	

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or funeral home. The attending physician and completely filled in by the attending physician. After this certificate has been signed by the attending physician and completely filled in by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8722

## CERTIFICATE OF DEATH

08679

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena, RFD</u> c. LENGTH OF STAY IN 1b <u>15 yrs.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena, RFD #1, Sillery Bay</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sillery Bay</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARLEN F. LOCHNER</u>		4. DATE OF DEATH Month Day Year <u>August 25, 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>24 Nov. 1912</u>
9. AGE (In years last birthday) <u>46</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas &amp; Elec. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leonard F. Lochner</u>		14. MOTHER'S MAIDEN NAME <u>Marie A. Haslup</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215101940</u>	
17. INFORMANT <u>Mrs. Jacqueline Bea Lochner</u>		Address <u>Case A3 #12</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion (Thrombosis)</u> DUE TO <u>Coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO (c) <u>Coronary sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>2</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>— 19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>—</u>
21. I certify that I attended the deceased from <u>February 1959</u> to <u>August 26, 1959</u> , that I last saw the deceased alive on <u>August 20, 1959</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>MOUNTAIN RD PASADENA, MD</u> DATE SIGNED <u>—</u>			
ACTUAL SIGNATURE <u>—</u>			
PHYSICIAN'S NAME (Type) <u>A. W. SCHEYER MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>29 Aug. 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cen.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>AUG 31 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneel</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

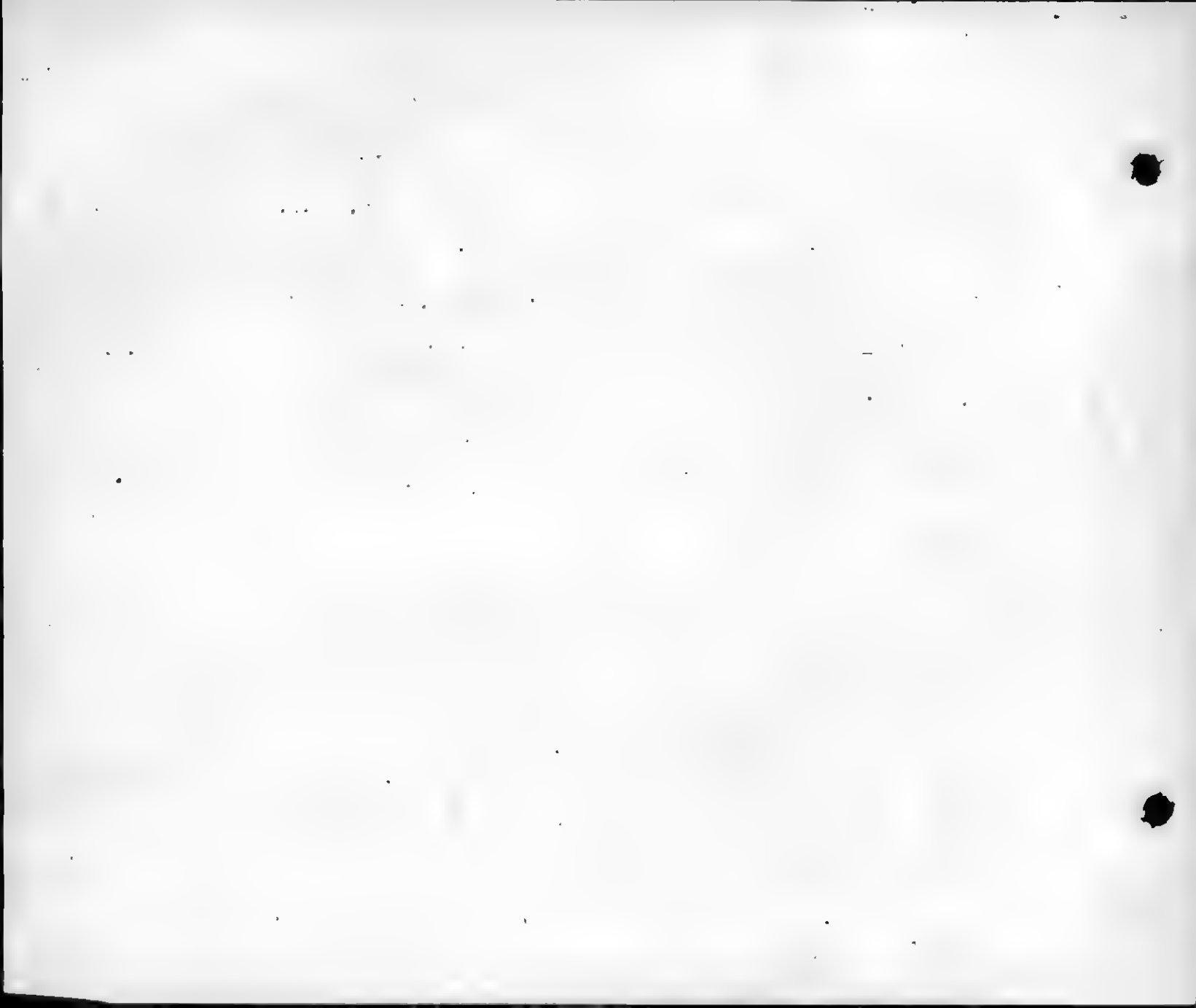
8675

## CERTIFICATE OF DEATH

Reg. Dist. No.

08680

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>10 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elsie</b> Middle <b>LOWMAN</b> Last <b>LOWMAN</b>		4. DATE OF DEATH Month <b>August</b> Day <b>26</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 27, 1873</b>
9. AGE (In years last birthday) <b>86</b> yrs		10. IF UNDER 1 YEAR Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min. <b>86</b>	11. IF UNDER 24 HRS. Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min. <b>86</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Musician- Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Lowman</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Hood</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Miss Edie Lowman</b>		Address <b>Sister same As # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Hemorrhage - 332X</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/25</b> , 19 <b>55</b> , to <b>8/26</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>8/26</b> , 19 <b>55</b> , and that death occurred at <b>5:40 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>121 CATHEDRAL ST Annapolis, Md</b> DATE SIGNED <b>8/26/59</b>			
ACTUAL SIGNATURE <b>Richard N. Peeler</b> M.D.		PHYSICIAN'S NAME (Type) <b>RICHARD N. PEELER ANNAPOLIS, MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>Aug. 29, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Nichols Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Odenton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping and Kirkley Funeral Home</b>		24a. REC'D BY REGISTRAR <b>Glen Burnie, Maryland</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>		DATE <b>AUG 31 '59</b>	



8723

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08681

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Green Haven, Pasadena</u>		c. LENGTH OF STAY IN lb <u>Few Instants</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>V1 Street</u>		d. STREET ADDRESS <u>V1 Street</u>	
3. NAME OF DECEASED (Type or print) <u>John Mack Jr.</u>		4. DATE OF DEATH Month <u>August</u> Day <u>17th.</u> Year <u>19 59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6/1/03</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar Tender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bar Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Mack Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Shade</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>216-10-6670</u>	
17. INFORMANT <u>Mr. Henry Mack (brother)</u>		Address <u>Glen Burnie, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c), stating the underlying cause last. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles S. Petty</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles S. Petty</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/17/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Spec. fy) <u>Burial</u>	22b. DATE THEREOF <u>August 20, 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping &amp; Kirkley</u>		24a. REC'D BY REGISTRAR <u>AUG 18 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Petty</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 to the State Board of Health. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



8724

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUND=L</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLENN BURNIE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLENN BURNIE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>139 SOLLY Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DANIEL</u> Middle <u>MCCLAIR</u> Last <u>MCCLAIR</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-13-98</u>
9. AGE (In years last birthday) <u>60</u> yrs		10. UNDER 1 YEAR IF UNDER 24 HRS Months <u>7</u> Days <u>8</u> Hours <u>10</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHAUFFEUR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TRUCKING</u>	
11. BIRTHPLACE (State or foreign country) <u>S.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>DANIEL MCCLAIR</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>YES IWW</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Lucille McClair</u>		Address <u>139 SOLLY, Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>10 DAY</u> <u>7-8 MOS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>58</u> , to <u>Aug 8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 7</u> , 19 <u>59</u> , and that death occurred at <u>4:30</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1532 Monument St</u> DATE SIGNED <u>Aug 10 '59</u>			
ACTUAL SIGNATURE <u>John Jones Jr.</u>		M.D. <u>1532 Monument St</u>	
PHYSICIAN'S NAME (Type) <u>Jeffrey Jones Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-12-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BALTO NATIONAL</u>	22d. LOCATION (City, town, or county) (State) <u>5501 FRIEDRICK AVE</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph B. Locks Jr.</u>		ADDRESS <u>1304 N. Central</u>	
24a. REC'D BY REGISTRAR <u>Aug 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 0246 8-10-59 et

## CERTIFICATE OF DEATH

8676

08683

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>			c. LENGTH OF STAY IN Yr <b>21 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. NAVAL HOSPITAL</b>				d. STREET ADDRESS <b>CARVEL HALL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELIZABETH MORLEY MC CLINTIC</b>				4. DATE OF DEATH Month Day Year <b>AUGUST 3 1959</b>			
5 SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 5, 1890</b>		9 AGE (In years last birthday) <b>69 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) <b>MASSACHUSETTS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>WALLACE MORLEY</b>				14. MOTHER'S MAIDEN NAME <b>EDITH KENDALL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. - - -		17. INFORMANT Address <b>U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PORTAL CIRRHOSIS OF THE LIVER</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>3 YEARS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>16 MARCH</b> , 19 <b>59</b> , to <b>3 AUGUST</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3 AUGUST</b> , 19 <b>59</b> , and that death occurred at <b>1035 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>R. Hochman</b> M.D.							
PHYSICIAN'S NAME (Type) <b>R. HOCHMAN LCDR MC USNR</b>				U.S. NAVAL HOSPITAL, ANNAPOLIS, Md. 8-4-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation Aug 5-59</b>		22b. DATE THEREOF <b>Aug 5-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cent</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Seelye Sons</b>				ADDRESS <b>Annapolis Md</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 6 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

8677

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>A.A.Co.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOIS ROADS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOIS ROADS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CAROLTON RD.</u>		d. STREET ADDRESS <u>CAROLTON RD.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>PEARL</u> Middle <u>M.</u> Last <u>McNABBY</u>	4. DATE OF DEATH Month <u>8</u> Day <u>29</u> Year <u>1959</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-23-1888</u>
9. AGE (in years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>FRANK B. WINKLER</u>		14. MOTHER'S MAIDEN NAME <u>CECILIA E. CREMP</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>WILLIAM J. McNABBY</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Hyper-tensive Cardiovascular</u> DUE TO <u>Dissecting Aortic Aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Cholelithiasis</u> DUE TO (c) <u>Chronic Cholelithiasis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/59</u> , 19, to <u>8/29/59</u> , 19, that I last saw the deceased alive on <u>8/29/59</u> , 19, and that death occurred at <u>6:47 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Amopolis Md</u> DATE SIGNED <u>8/24/59</u>			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>[Signature]</u>	
PHYSICIAN'S NAME (Type) <u>E. L. W. HART</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 2-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Akron Ohio</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Taylor Sons</u>		24a. REC'D BY REGISTRAR <u>SEP 1 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur &amp; Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

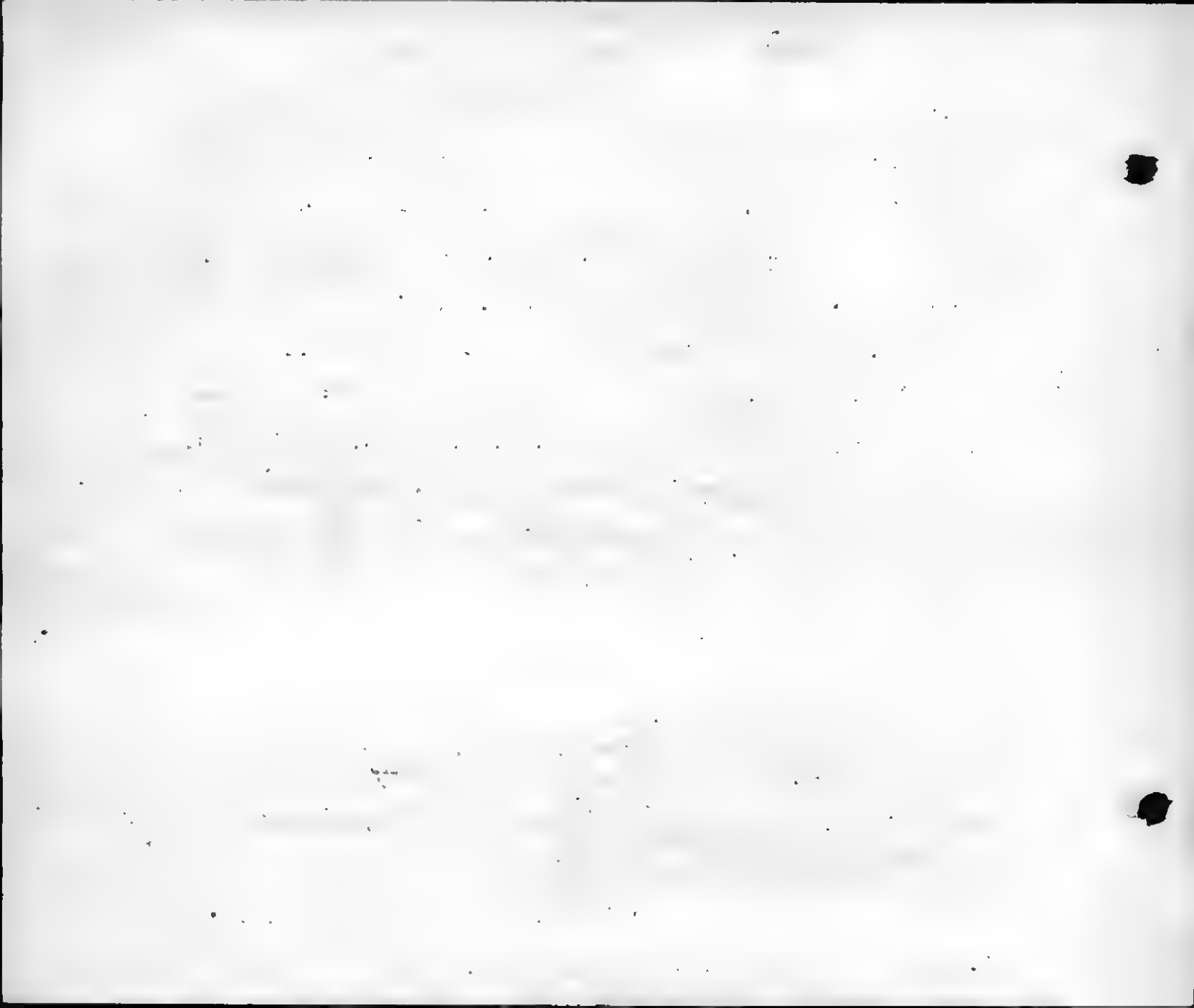
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15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8725 . CERTIFICATE OF DEATH

08685

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>AA</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Glen Burnie</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1103 Wilson Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>R.</b> Last <b>Meredith</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 23, 1889</b>
9. AGE (In years lost birthday) <b>70</b> yrs		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>4</b> Hours <b>30</b> Min.	
10a. J.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Meyers</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Conrad</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, (If yes, give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>INFORMANT 1831 Ramsey Street J. G. E. Mabus, Balto, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> DUE TO (b) <b>Cardiovascular System Disease</b> DUE TO (c) <b>Anaesthesia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>3 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1 - 59</b> to <b>Aug 3 - 59</b> , that I last saw the deceased alive on <b>July 30 - 1959</b> , and that death occurred <b>2:30 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>8/4-59</b>			
ACTUAL SIGNATURE <b>R. JOSEPH LIPSKEY</b> PHYSICIAN'S NAME (Type)		DATE SIGNED <b>8/4-59</b>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/6/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b>		22d. LOCATION (City, town, or county) (State) <b>Howard County</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping and Kirkley</b> ADDRESS <b>Glen Burnie, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 5 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. K...</b>			



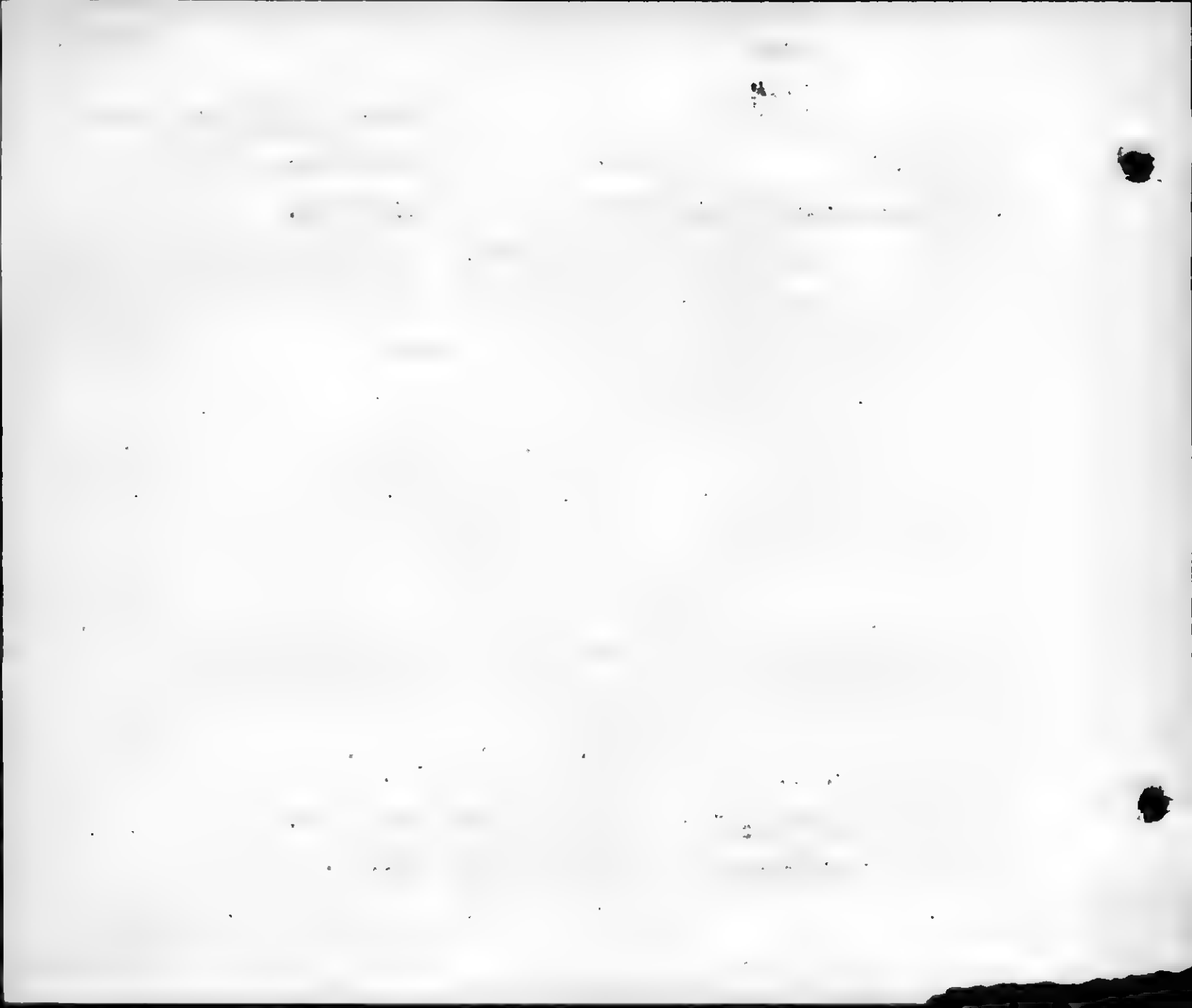
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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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8678  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

08686

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>12 hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>(Mayer)</b> Last <b>MEYERS</b>		4. DATE OF DEATH Month <b>August</b> Day <b>18</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/29/82</b>
9. AGE (In years lost birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min.	11. IF UNDER 24 HRS Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>Austria</b> ✓	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>		16. SOCIAL SECURITY NO. <b>--</b>	
INFORMANT <b>Mr. John V. King</b>		Address <b>N. Linthicum</b> <b>31 Milton Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>440.1</b> DUE TO (c) <b>440.1</b>			INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Tumor of colon</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 17, 19 59</b> to <b>Aug. 17, 19 59</b> that I last saw the deceased alive on <b>Aug. 17, 1959</b> and that death occurred at <b>6:00AM</b> , from the causes and on the date stated above			
ACTUAL SIGNATURE <b>John Hodeman</b>		ADDRESS (Street, city or town, state) <b>121 Cathedral St.,</b> DATE SIGNED <b>8/18/59</b>	
PHYSICIAN'S NAME (Type) <b>John Hodeman</b>		Annapolis, Md.	
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/22/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. DENNY, INC.</b>		ADDRESS <b>715 Light St.</b>	
DATE <b>Baltimore, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 21 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			





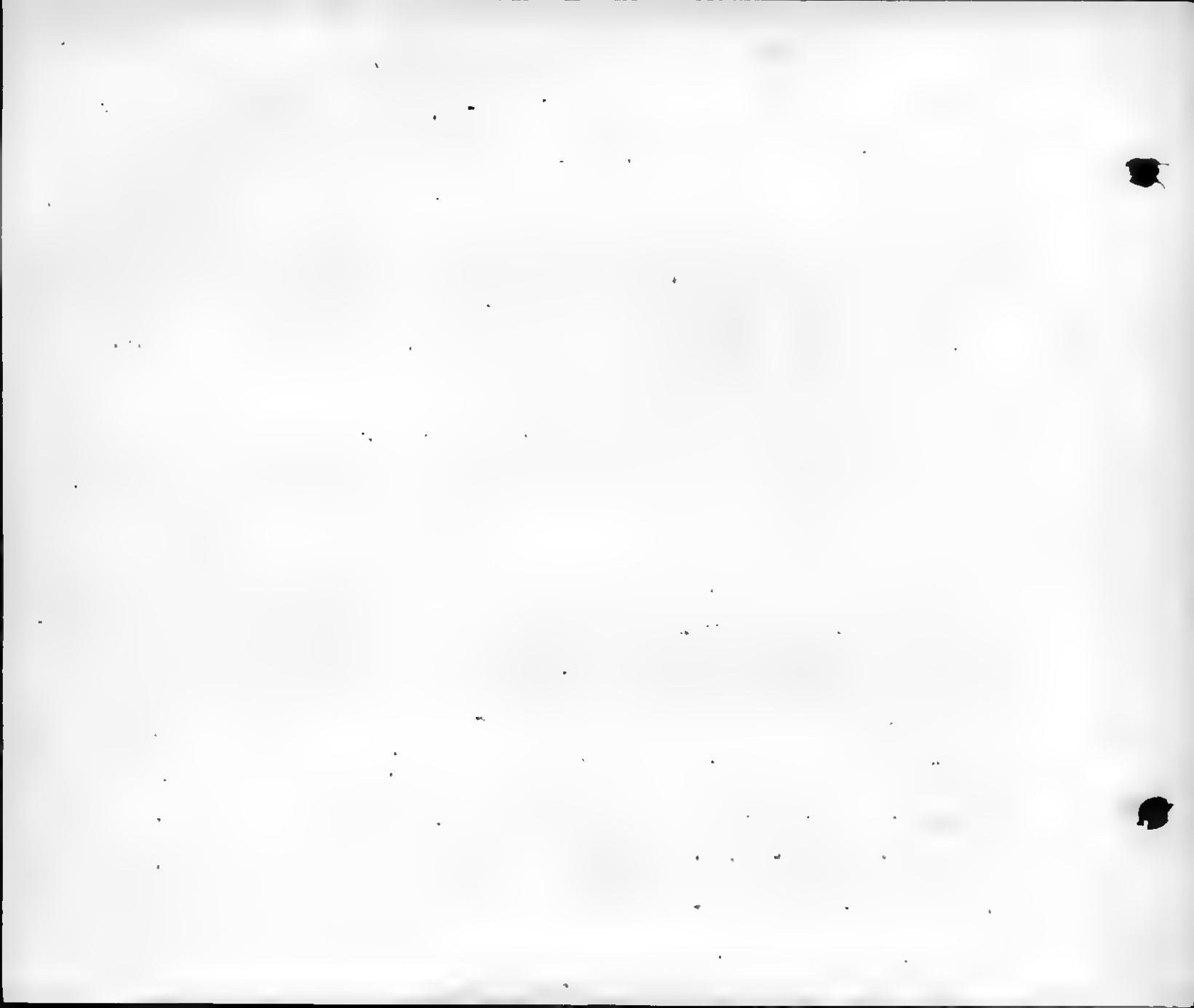
08687

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 4 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>45yrs. 18 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>Unknown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Henry</b>		First <b>Henry</b>		Middle <b>Miller</b>		Last <b>Miller</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1890</b>	
9. AGE (In years last birthday) <b>69</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Miller</b>				14. MOTHER'S MAIDEN NAME <b>Phoebe?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <b>522X</b> DUE TO <b>Hypostatic Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis with Mental Deficiency</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. ----- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/13/14</b> 19 <b>59</b> , to <b>8/1</b> 19 <b>59</b> , that I last saw the deceased alive on <b>8/1</b> 19 <b>59</b> , and that death occurred at <b>6:40P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State hospital, Md.</b> DATE SIGNED <b>8/3/59</b> ACTUAL SIGNATURE <b>L. Benedict, M. D.</b> M.D. <b>Crownsville State hospital, Md.</b> <b>8/3/59</b> PHYSICIAN'S NAME (Type) <b>Crownsville State Hospital, Md.</b> <b>8/3/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>8-4-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Anatomy Board</b>		22d. LOCATION (City, town, or county) (State) <b>University of Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John W. [Signature]</b>				ADDRESS <b>108 W. [Address]</b>		24a. REC'D BY REGISTRAR <b>AUG 5 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. [Signature]</b>			



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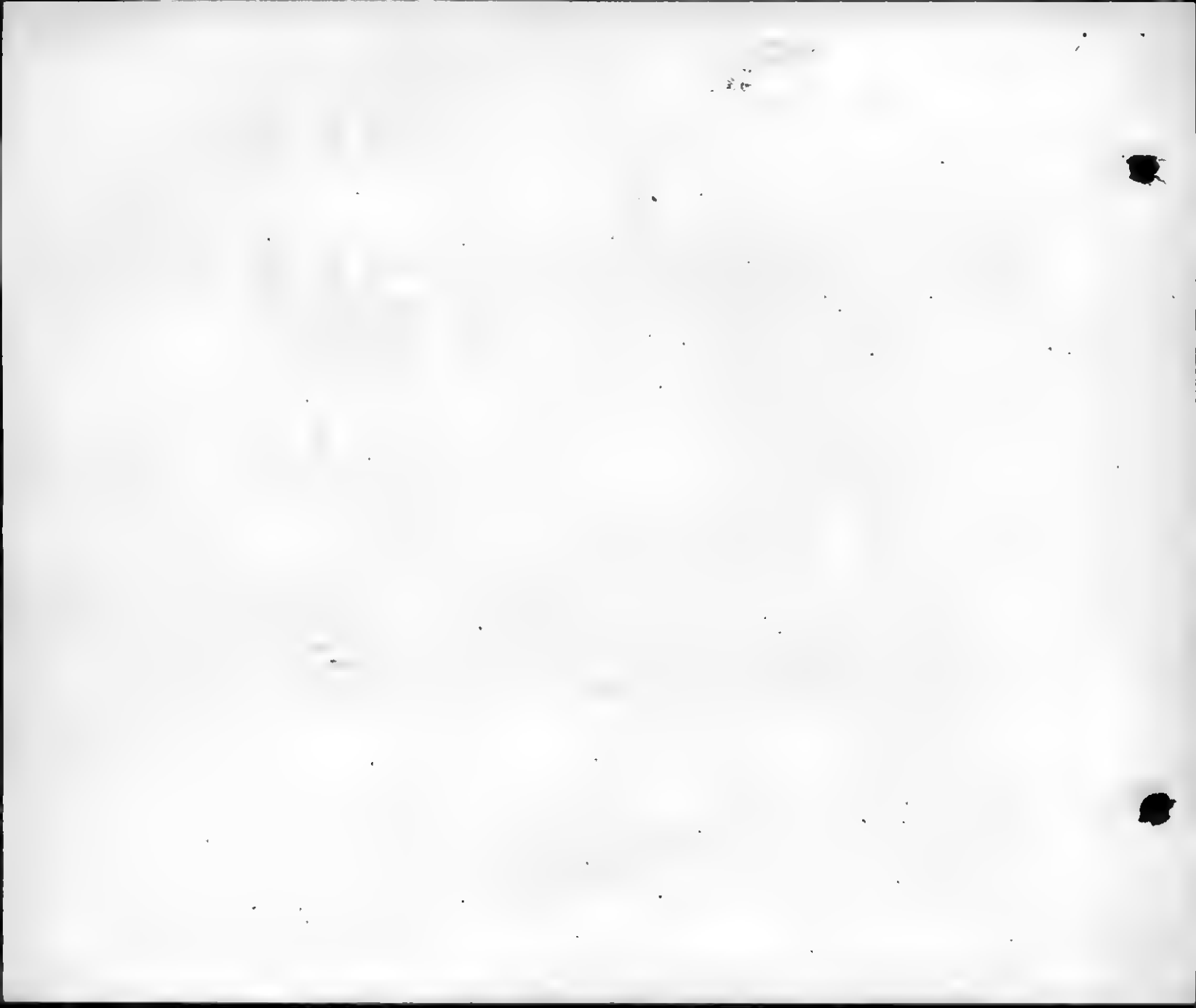
CERTIFICATE OF DEATH

08688

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> , MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>DEALE</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>DEALE</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Anne Arundel General Hospital</i>		e. STREET ADDRESS <i>CHALK POINT RD</i>	
3. NAME OF DECEASED (Type or print) <i>Renix B. Miller</i>		4. DATE OF DEATH <i>August 15 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug-18-1886</i>
9. AGE (In years lost birthday) <i>72</i> yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>D.C. TRANSIT</i>	
11. BIRTHPLACE (State or foreign country) <i>West VA.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>HENRY MILLER</i>		14. MOTHER'S MAIDEN NAME <i>NANCY GOOF</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO <i>Elizabeth Miller Same as #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aortic stenosis &amp; heart failure &amp; circulatory collapse</i> 421.1 DUE TO (b) <i>421.1</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) <i>421.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bronchial pneumonia, dehydration</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>August 14, 1959</i> to <i>August 15, 1959</i> , that I last saw the deceased alive on <i>August 14, 1959</i> , and that death occurred at <i>12:55 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Willard F. Smith</i> M.D.		ADDRESS (Street, city or town, state) <i>Shady Side, Maryland</i> DATE SIGNED <i>8/16/59</i>	
PHYSICIAN'S NAME (Type) <i>WILLARD F. SMITH, MD</i>			
22a. BURIAL, CREMATON, REMOVAL (Specify) <i>BURIAL Aug 18-59</i>		22b. DATE THEREOF <i>Aug 18-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>CEDAR HILL</i>		22d. LOCATION (City, town, or county) (State) <i>SWITLAND MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>SIMMONS BROS</i> ADDRESS <i>1661 GOOD HOPE RD. SE WASH. D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 17 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 of 1. The law requires that the death certificate be executed within 24 hours of death. Page 1 of 1. The law requires that the death certificate be executed within 24 hours of death. Page 1 of 1.

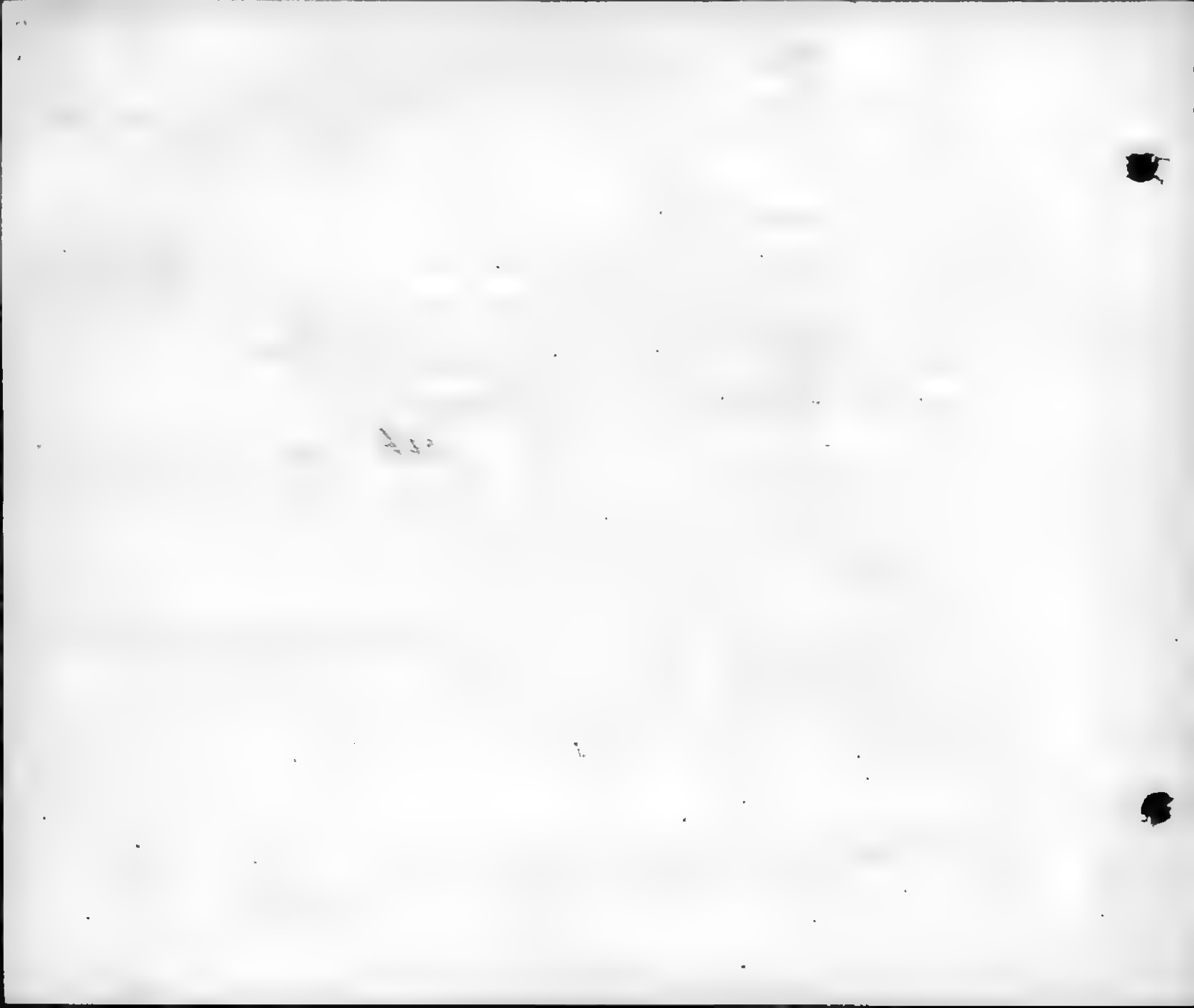


8680

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GENERAL</u>		e. STREET ADDRESS <u>310 THIRD ST.</u>	
3. NAME OF DECEASED (Type or print) <u>Uellie E. Mohler</u>		4. DATE OF DEATH Month <u>8</u> Day <u>27</u> Year <u>1959</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 16 1888</u>
9 AGE (In years last birthday) <u>70 1/2</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSE WIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JOHN WATERS</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Miviter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>IAH</u>	
17. INFORMANT <u>MRS. JOSEPH TEE</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema. Pulat Hydropneumothorax 9 hrs.</u> DUE TO (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) <u>Rheumatic Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>9 hrs.</u> <u>yes</u> <u>yes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cancer of caecum - metastatic to ovum &amp; other abdominal organs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/27/59</u> , 19 <u>59</u> , to <u>8/27/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/27/59</u> , 19 <u>59</u> , and that death occurred at <u>2:05 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice F. Klawans</u> M.D.		ADDRESS (Street, city or town, state) <u>31 Southgate Ave</u> DATE SIGNED <u>8/27/59</u>	
PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAUANS</u>		<u>Annapolis Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>8-30-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		ADDRESS <u>Annapolis Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

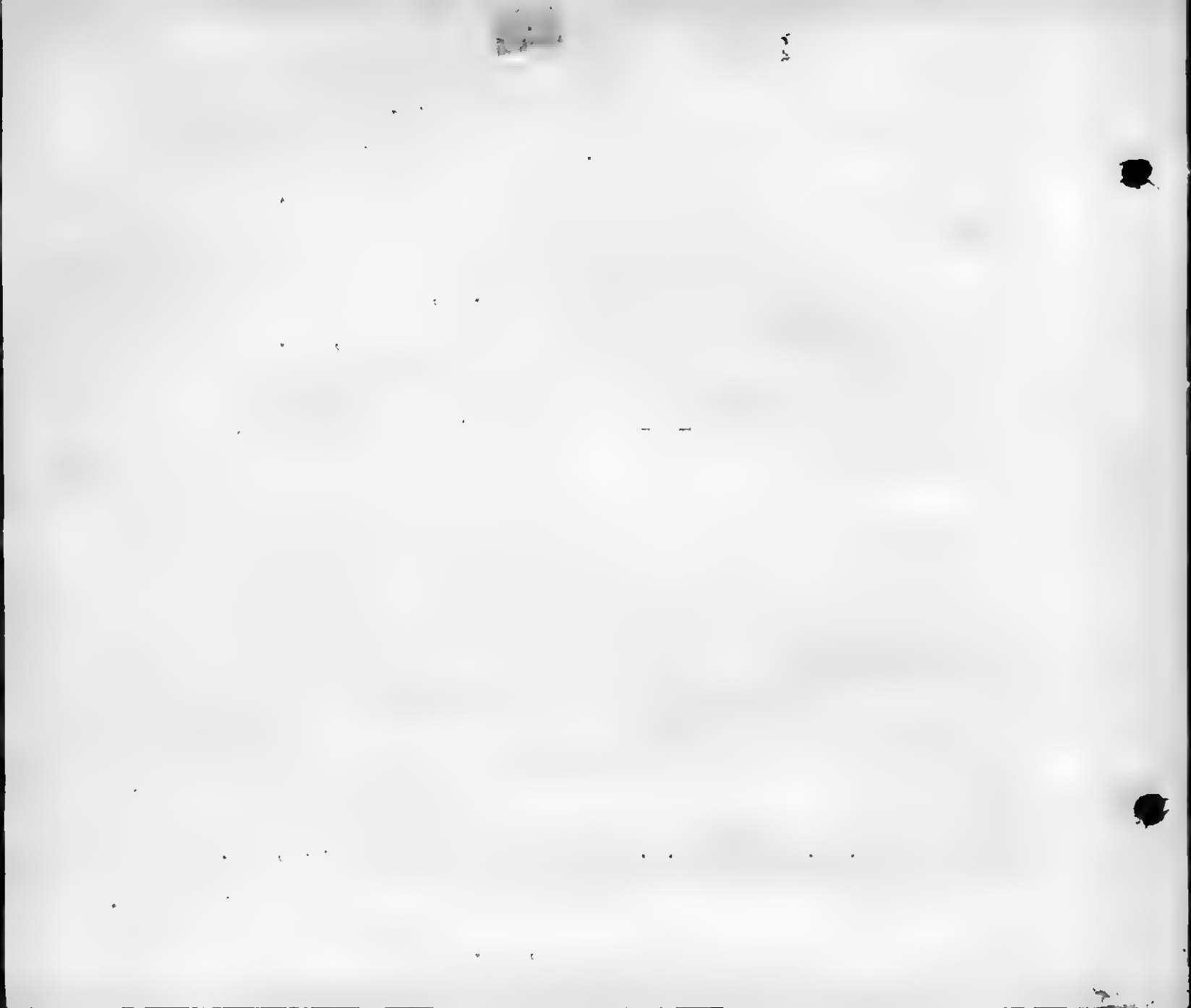
8727

## CERTIFICATE OF DEATH

08690

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>AA</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>			c. LENGTH OF STAY IN lb <b>12 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Glen Burnie</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>206 Fourth Ave SE</b>				f. d. STREET ADDRESS <b>206 Fourth Ave, SE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Thomas</b> Last <b>Montgomery</b>				4. DATE OF DEATH Month <b>August</b> Day <b>15</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 25, 1892</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tug Boat Captain</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Deltaville, Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John Montgomery</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann Kellum</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>none</b>				16. SOCIAL SECURITY NO <b>212-16-2573</b>		17. INFORMANT Address <b>Mrs William Beardmore, same as 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>201X</b> DUE TO <b>Myocardial Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July 6, 1959</b> to <b>Aug 15, 1959</b> , that I last saw the deceased alive on <b>August 7, 1959</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>B. L. Jones, M.D.</b> <b>Glen Burnie, Md.</b> <b>Aug 17, 1959</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>August 18, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross</b>	
22d. LOCATION (City, town, or county) (State) <b>Baltimore 25, Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping and Kirkley</b> ADDRESS <b>Glen Burnie, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 18 1959</b>		24b. REGISTRAR'S SIGNATURE <b>William L. Thomas</b>	

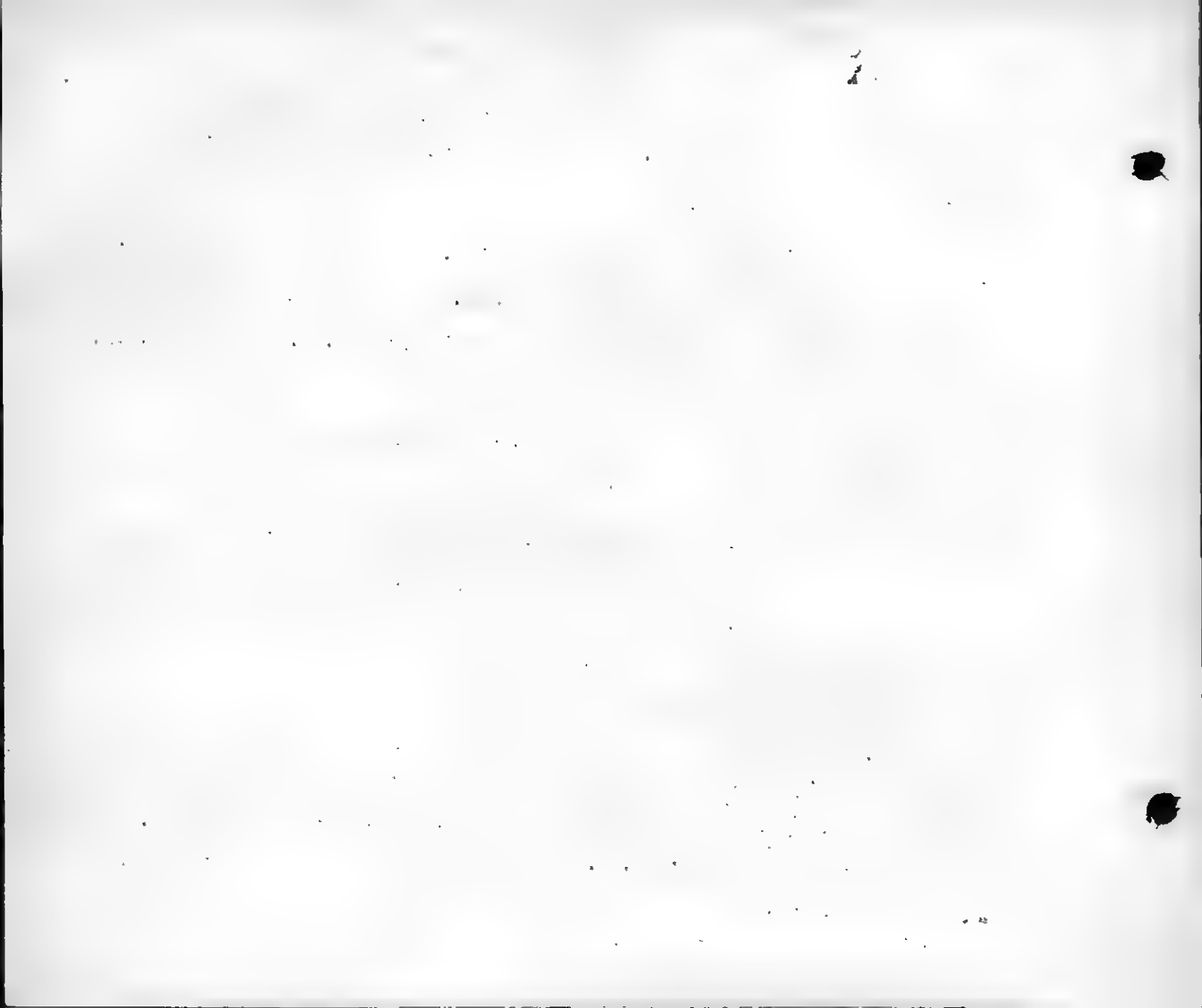




TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
8723									
CERTIFICATE OF DEATH									
Reg. Dist. No. 08691									
1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>4mo. 17 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>					2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3336 Piedmont Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>Marcella ELLA Moore</b>					4. DATE OF DEATH Month Day Year <b>8 12 19 59</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-11-1899</b>		9. AGE (In years last birthday) <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Harry Parks</b>					14. MOTHER'S MAIDEN NAME <b>Leveana</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT <b>Hospital Records</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anemia and malnutrition</b> <b>DOAX</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Brain Syndrome</b> DUE TO (c) <b>Cerebral and generalized Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Right Hemiplegia, Flexura Contractures, Decubitus Ulcers</b> INTERVAL BETWEEN ONSET AND DEATH									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -----							
20c. TIME OF INJURY Month Day Year Hour <b>-----</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County) (State)	
21 I certify that I attended the deceased from <b>3/25</b> , 19 <b>59</b> , to <b>8/12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/12</b> , 19 <b>59</b> , and that death occurred at <b>3:50 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>8/12/59</b>									
ACTUAL SIGNATURE <b>Lionel McHenry Mapp, M. D.</b>		M.D. <b>Crownsville State Hospital, Md. 8/12/59</b>							
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>		M.D. <b>Crownsville State Hospital, Md. 8/12/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 16 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ambitus</b>		22d. LOCATION (City, town, or county) <b>and</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Wilson 1348 N. Calhoun St</b>				ADDRESS <b>1348 N. Calhoun St</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Hanna</b>	



**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

8729

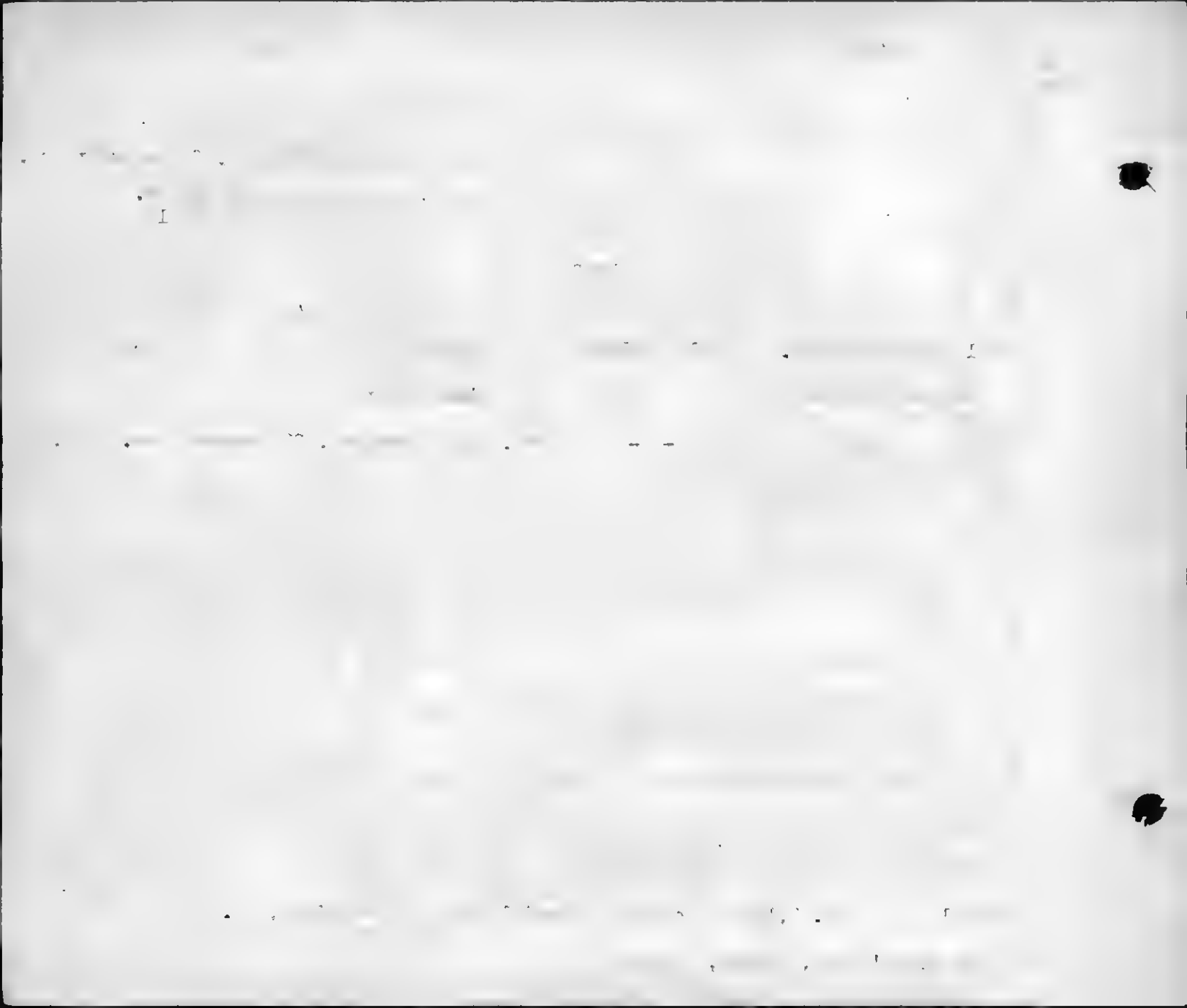
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08692

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANCO.</u> b. CITY OR TOWN (If out of corporate limits write RURAL and give nearest town) <u>BAY RIDGE.</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institut on: give name and address) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE.</u> <u>33 Regester Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - ANNE. Reuter. Gens.</u>		e. STREET ADDRESS <u>33 Regester Ave.</u> Balto. 12	
3. NAME OF DECEASED (Type or print) <u>First</u> <u>Harold H.</u> <u>Middle</u> <u>Ernest</u> <u>Last</u> <u>Mueller.</u>		4. DATE OF DEATH <u>Month</u> <u>8</u> <u>Day</u> <u>30</u> <u>Year</u> <u>1959.</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-10</u>
9. AGE (In years last birthday) <u>48</u> yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate and Ins.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ernest Mueller</u>		14. MOTHER'S MAIDEN NAME <u>Mina Kohler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>- -</u>	
17. INFORMANT <u>Mrs. Lucile Mueller, 33 Regester Ave. Balto. 12</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>470.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>12</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>F. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 2, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Parkville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Maryland</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>SEP 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

2



FOR STATE  
HEALTH DEPT.

8730

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08693

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Anne

M

1. PLACE OF DEATH a. COUNTY <u>Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Severna Park</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 2 Box 507</u>				e. STREET ADDRESS <u>Same</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Edna</u> <u>Munroe</u>				4. DATE OF DEATH Month Day Year <u>Aug.</u> <u>3rd.</u> <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/13/90</u>	
9. AGE (In years last birthday) <u>69</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Social Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Samuel W.T. Daley</u>				14. MOTHER'S MAIDEN NAME <u>Ida S. Robinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>2240-58-3296</u>		17. INFORMANT Address <u>Mrs. Priscilla Hembree (daughter)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>							
DUE TO (b) <u>Diabetes</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>Many years.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>8/3/59</u>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Interment 8/6/59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		22d. LOCATION (City, town, or county) (State) <u>Belle 2-Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Shirley M. Mowbray</u>				24a. REC'D BY REGISTRAR ADDRESS <u>108 W. 4th St</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



FOR STATE  
HEALTH DEPT.

8731

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08694

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived (if institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Meade</u>		c. LENGTH OF STAY IN 1b <u>6 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fort Meade Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>	
		f. STREET ADDRESS <u>Route 2 Box 39</u>	
3. NAME OF DECEASED (Type or print) <u>James Newsome</u>		4. DATE OF DEATH <u>Aug. 21st</u> 19 <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/16/91</u>
9. AGE (in years last birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired fisherman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>North Carolina.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Newsome</u>		14. MOTHER'S MAIDEN NAME <u>Mary Waley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>17. INFORMANT</u>	
		Address <u>Mrs. Edith Todd, Little River, N.C. (Grand daughter)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic heart diseases</u> (c) <u>Arteriosclerotic heart diseases</u> DUE TO (a) stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8/22/59</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/25/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN F. DENNY, INC. 715 Light St.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 25 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
BALTO.-30, Md.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





8732

CERTIFICATE OF DEATH

08695

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marley Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Marley Park</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>21 Cedar Drive</b>		d. STREET ADDRESS <b>21 Cedar Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>H.</b> Last <b>OSHE</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>21</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 21, 1866</b>
9. AGE (In years last birthday) yrs <b>93</b>		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(ret'd) Glass Blower</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth (unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Mamie L. Houston, 1326 Birch Ave, Zone 27</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC DECOMPENSATION</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROSIS GENERAL</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept. 1949</b> to <b>Aug. 21, 1959</b> , that I last saw the deceased alive on <b>August 18, 1959</b> , and that death occurred at <b>4 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bryant L. Jones</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>104 Chain Highway S 8/21/59</b>	
PHYSICIAN'S NAME (Type) <b>BRYANT L. JONES, M.D. Glen Burnie Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8-25-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 25 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kane</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



08696

8733

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anno Arundel</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived If institution Residence before admission) a. STATE <b>Same</b> b. COUNTY <b>Same</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>P.O. Severna Park</b>		c. LENGTH OF STAY IN 1b <b>2 weeks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Earleigh Heights Rd.</b>		e. STREET ADDRESS <b>Same</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>George Thomas Palmer</b>			
<b>5. SEX</b> <b>M</b>		<b>6. COLOR OR RACE</b> <b>C.</b>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>9/26/93</b>	
<b>9. AGE</b> (In years last birthday) <b>65</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>11. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farm hand, laborer.</b>		<b>12. BIRTHPLACE</b> (State or foreign country) <b>Virginia</b>	
<b>13. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>14. FATHER'S NAME</b> <b>Ben. Palmer</b>	
<b>15. MOTHER'S MAIDEN NAME</b> <b>Maggie ?</b>		<b>16. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service)	
<b>17. SOCIAL SECURITY NO.</b>		<b>18. INFORMANT</b> <b>Mrs. Frances Palmer (wife)</b>	
<b>19. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Coronary Occlusion</b> <b>if ? / DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</b> <b>DUE TO</b> <b>(b)</b> <b>(c)</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)</b> <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Sudden</b>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>20c. TIME OF INJURY</b> Hour <b>a. m.</b> <b>p. m.</b> <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <b>Gustave H. Faubert, M.D.</b>		<b>DATE SIGNED</b> <b>8/24/59</b>	
<b>EXAMINER'S NAME (Type)</b> <b>Gustave H. Faubert, M.D.</b>		<b>22a. REC'D BY REGISTRAR</b> <b>SEP 1 59</b>	
<b>22b. DATE THEREOF</b> <b>8-29-59</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Robinson</b>	
<b>22d. LOCATION (City, town, or county)</b> <b>md.</b>		<b>22e. REGISTRAR'S SIGNATURE</b> <b>Charles E. Hicks</b>	
<b>22f. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Charles E. Hicks</b>		<b>22g. ADDRESS</b> <b>43 Northwest St</b>	

**TO DEPUTY MEA:** EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

8734

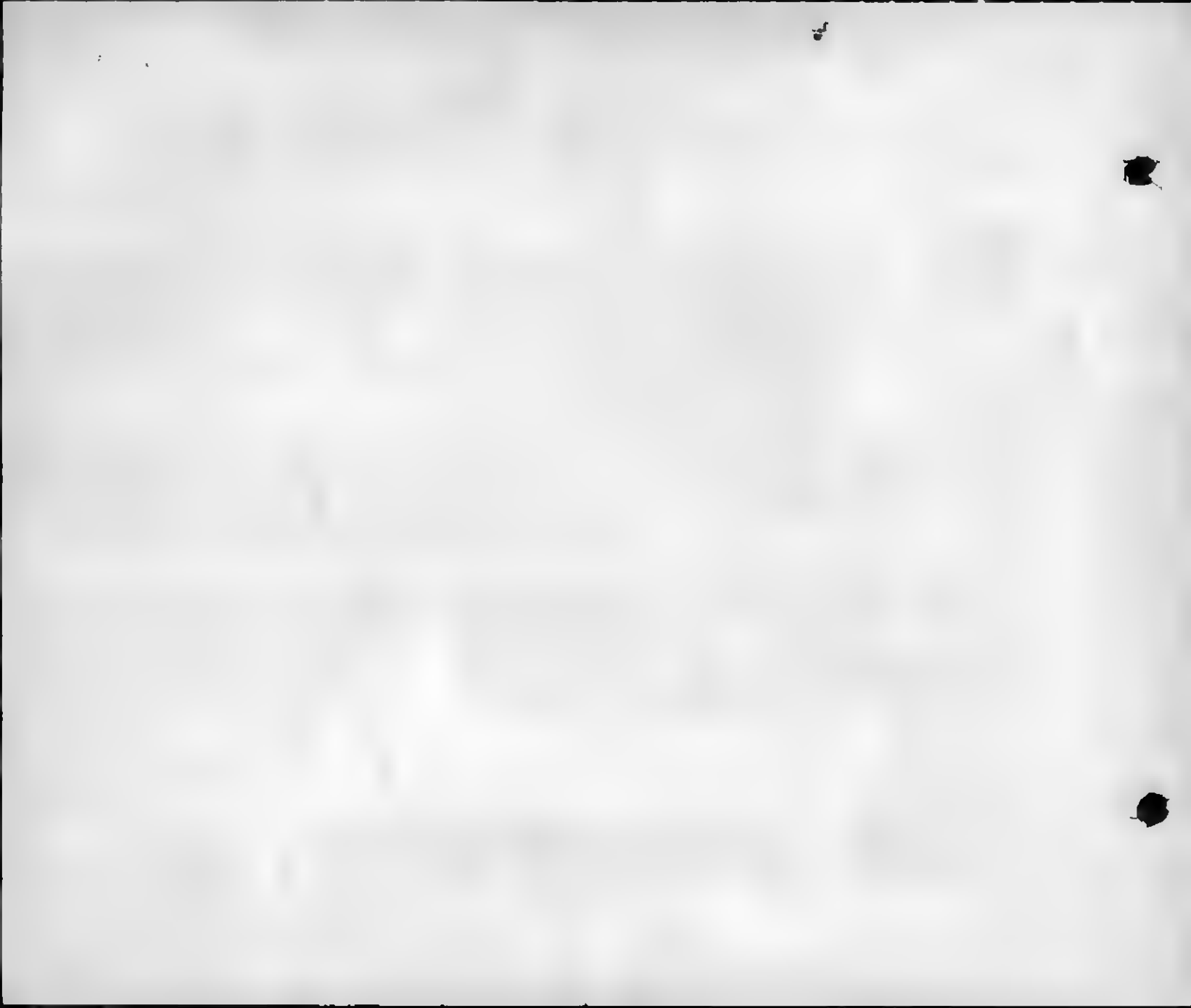
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08697

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Nr. Crownsville</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Near Crownsville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 178</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Norman</u> Middle <u>Terrell</u> Last <u>PARKER</u>			4. DATE OF DEATH Month <u>9</u> Day <u>6</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-19-1905</u>	9. AGE (in years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxi Operator</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Taxi</u>		
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Charles F. Parker</u>			14. MOTHER'S MAIDEN NAME <u>Delphia Lewis</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Elka E. Parker Macleodfield</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.0</u> DUE TO <u>Heart disease</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>  </u>					
DUE TO (c) <u>  </u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>E. L. Howard</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/6/59</u>	
EXAMINER'S NAME (Type) <u>E. L. Howard</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-9-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parker Family Cem</u>	22d. LOCATION (City, town, or county)	(State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Doyle</u>			24a. REC'D BY REGISTRAR <u>  </u>	24b. REGISTRAR'S SIGNATURE <u>  </u>	
DATE <u>AUG 10 '59</u>					

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 2248 9-8-59 et

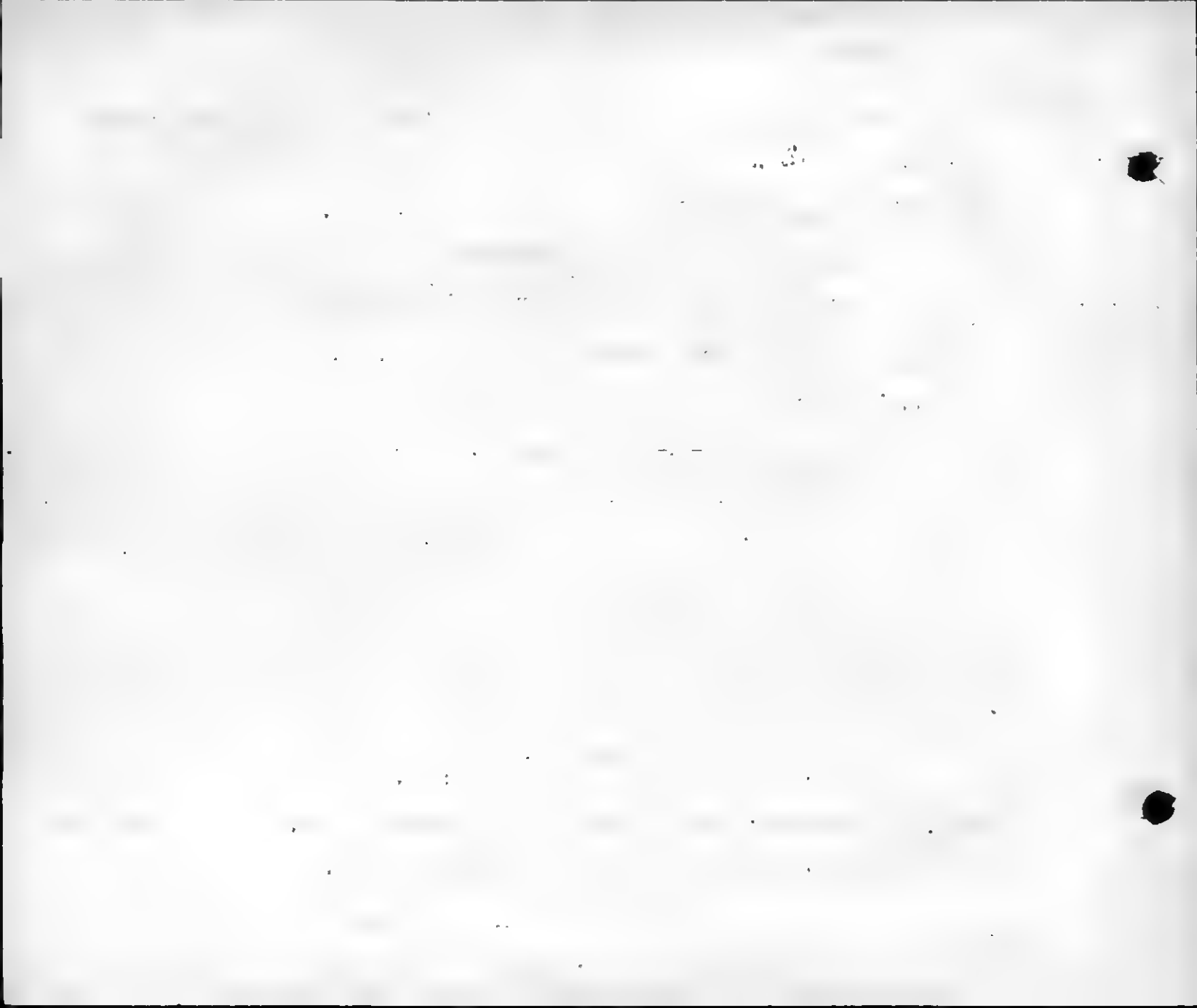
8681

## CERTIFICATE OF DEATH

08698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>113 Main St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>PARKINSON</b> Last <b>PARKINSON</b>				4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 27, 1897</b> <b>August 20, 1952</b>	9. AGE (In years last birthday) <b>61 1/2</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self employed</b>		11. BIRTHPLACE (State or foreign country) <b>Annapolis, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Parkinson</b>				14. MOTHER'S MAIDEN NAME <b>Stella Davy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>213-16-5916</b>		INFORMANT Address <b>Mr. Wm. O. Beall- 122 Granville Ave. Annapolis, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <b>180X</b> IMMEDIATE CAUSE (a) <b>12 AVIATION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARCINOMA OF KIDNEY, METASTATIC</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>12 DAYS</b> <b>5 YEARS</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 24, 1959</b> to <b>August 29, 1959</b> , that I last saw the deceased alive on <b>August 29, 1959</b> , and that death occurred at <b>1:12 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>41 Southgate Ave., Annapolis, Md.</b> DATE SIGNED <b>8/31/59</b>							
ACTUAL SIGNATURE <b>Edward S. Beck</b>		M.D. <b>Edward S. Beck</b>					
PHYSICIAN'S NAME (Type) <b>Edward S. Beck</b>		<b>Annapolis, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 1, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>				ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 2 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chilton E. Kline</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8682

## CERTIFICATE OF DEATH

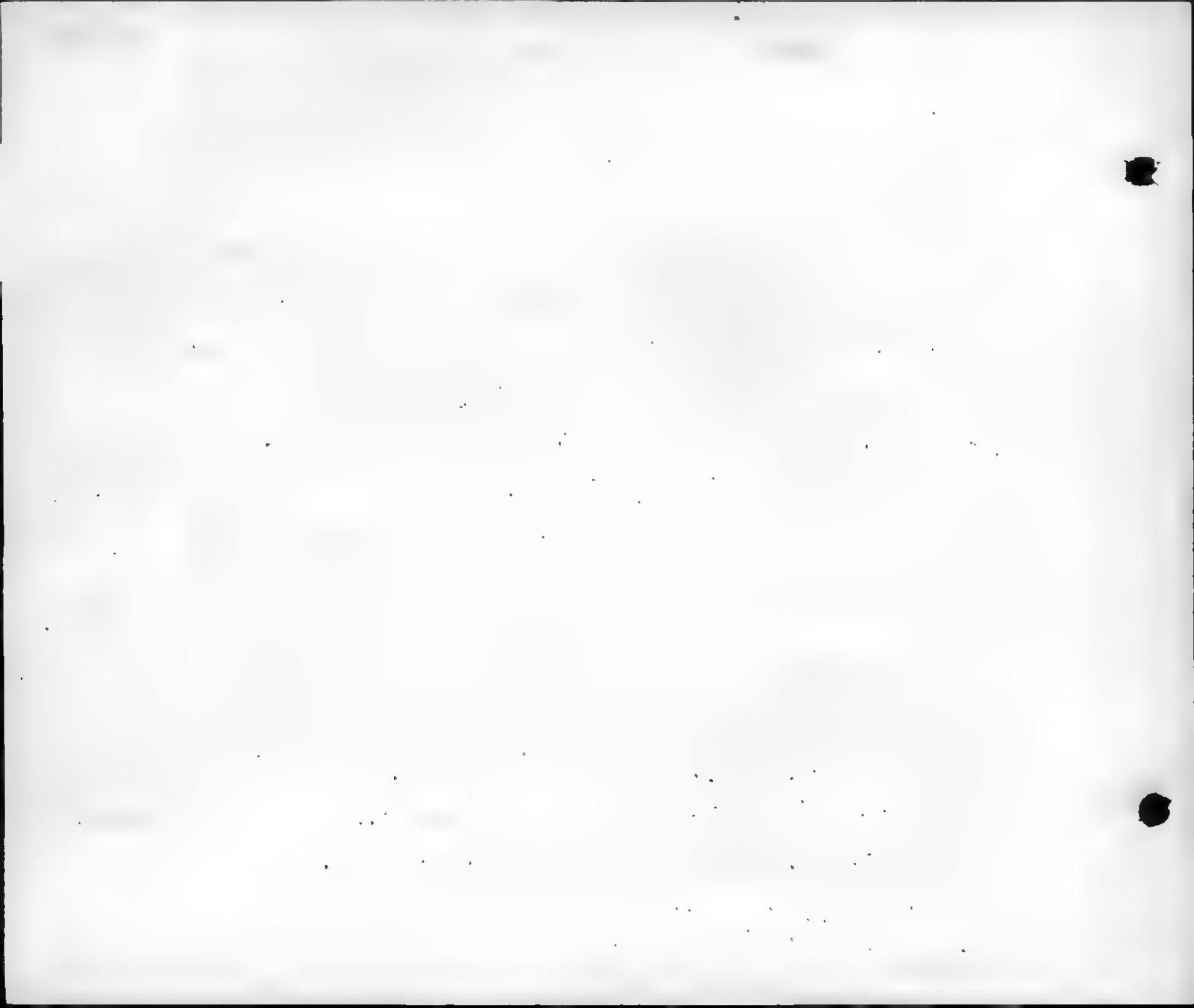
08699

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>AA</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>AA.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN 1b <b>5 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General</b>				d. STREET ADDRESS <b>110 A East</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>ALFONSA</b> Last <b>PARKS</b>				4. DATE OF DEATH Month <b>August</b> Day <b>11</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 16 1890</b>		9. AGE (In years last birthday) <b>68 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. NAVY</b>		11. BIRTHPLACE (State or foreign country) <b>A.A. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>W.H.F. Parks</b>				14. MOTHER'S MAIDEN NAME <b>Alice R. Lyles</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WWI</b>		16. SOCIAL SECURITY NO. <b>---</b>		INFORMANT <b>Mrs. Lida M. Firmer</b>		Address <b>Annapolis Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (b), (c), and (d).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4:11</b> <b>ilgostemia</b> DUE TO <b>cardiac failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>intense sclerotic heart disease with</b> DUE TO <b>Cardiac Failure</b> (c) <b>Cardiac Failure</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>17h</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 6, 19 59</b> , to <b>August 11, 19 59</b> , that I last saw the deceased alive on <b>August 10, 19 59</b> , and that death occurred at <b>4:14 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6 Shaw St.,</b> DATE SIGNED <b>8/11/59</b>							
ACTUAL SIGNATURE <b>James R. Martin</b> M.D.				DATE SIGNED <b>8/11/59</b>			
PHYSICIAN'S NAME (Type) <b>James R. Martin</b>				Address <b>Annapolis, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 13/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodfield Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lakeside Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard Hardisty</b>				24a. REC'D BY REGISTRAR <b>AUG 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Finney</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERARY PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8735

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

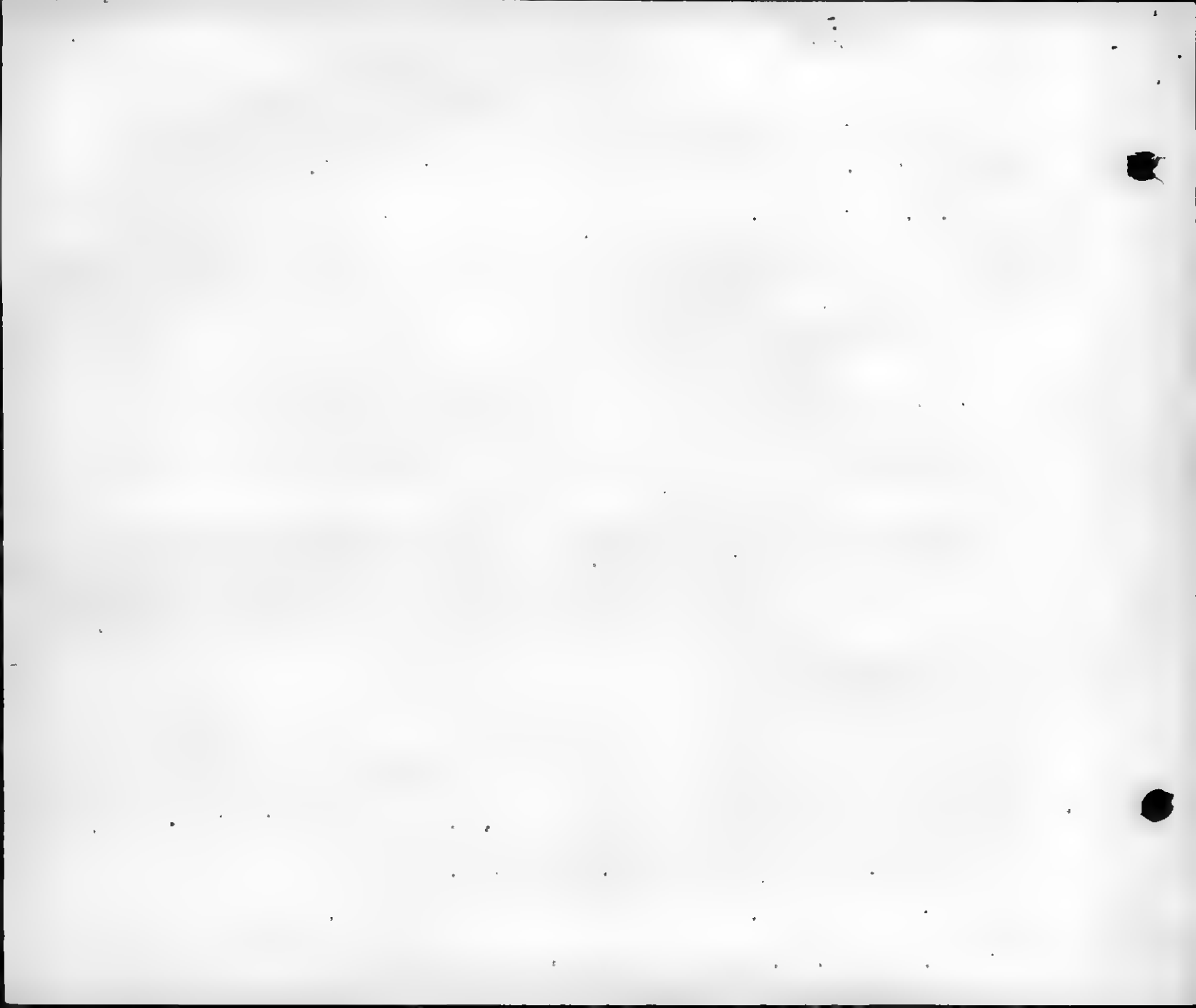
09837

# CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade, Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				d. STREET ADDRESS <u>7221 - D Hall Street</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Peter</u> Last <u>Pawlak</u>				4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 Aug 1959</u>		9. AGE (In years last birthday) yrs. <u>2</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Pater Pawlak</u>				14. MOTHER'S MAIDEN NAME <u>Bessiem Olmstead</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>n/a</u>		16. SOCIAL SECURITY NO. <u>n/a</u>		INFORMANT Address <u>Father, Peter Pawlak, 7221 D Street, Ft Meade, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u> <u>760.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>Blood coagulation defect specific factor involved</u> <u>not confirmed.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>24 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1959</u> Hour <u>o. m.</u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 Aug</u> , 19 <u>59</u> , to <u>21 Aug</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>21 August</u> , 19 <u>59</u> , and that death occurred at <u>1210p</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilbur H. Miller, Jr.</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>21 Aug 1959</u>			
PHYSICIAN'S NAME (Type) <u>WILBUR H. MILLER, JR., Capt., MC</u>				<u>U. S. Army Hospital, Ft Geo G Meade, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>21 August 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laboratory, USAH, Fort George G. Meade, Maryland</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Betty M. Ellis, Capt., MC, Ft Geo G Meade, Md</u>				ADDRESS <u>USAH</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 11 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>William H. Miller</u>							

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08700	
Items 18-21 File 8736										Item 2 File 6289-1-59	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. LENGTH OF STAY IN 1b						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fort Smallwood Park</b>					d. STREET ADDRESS <b>648 Newton Pl. N. W. District Training School</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HILTON</b> Middle Last <b>PEED</b>					4. DATE OF DEATH Month <b>August</b> Day <b>26</b> Year <b>1959</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 18, 1926</b>		9. AGE (In years last birthday) <b>33</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Richmond County, Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Conway Peed</b>					14. MOTHER'S MAIDEN NAME <b>Lara Oliff</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>J. J. Noone</b> <i>Subt.</i>			Address <b>District Training School</b>		
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> <b>729.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Found drowned</b>							
20c. TIME OF INJURY Month, Day, Year <b>11:35 a. m. 8/26/59</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Water</b>		20f. (City or town) <b>Anne Arundel</b>		(County) (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>W. Bradley King, Jr.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>8/26/59</b>			
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8-31-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Suitland, Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company,</b>						ADDRESS <b>14th and Chapin St., N. Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>8/28/59</b>		24b. REGISTRAR'S SIGNATURE <b>C. J. ...</b>	



8737

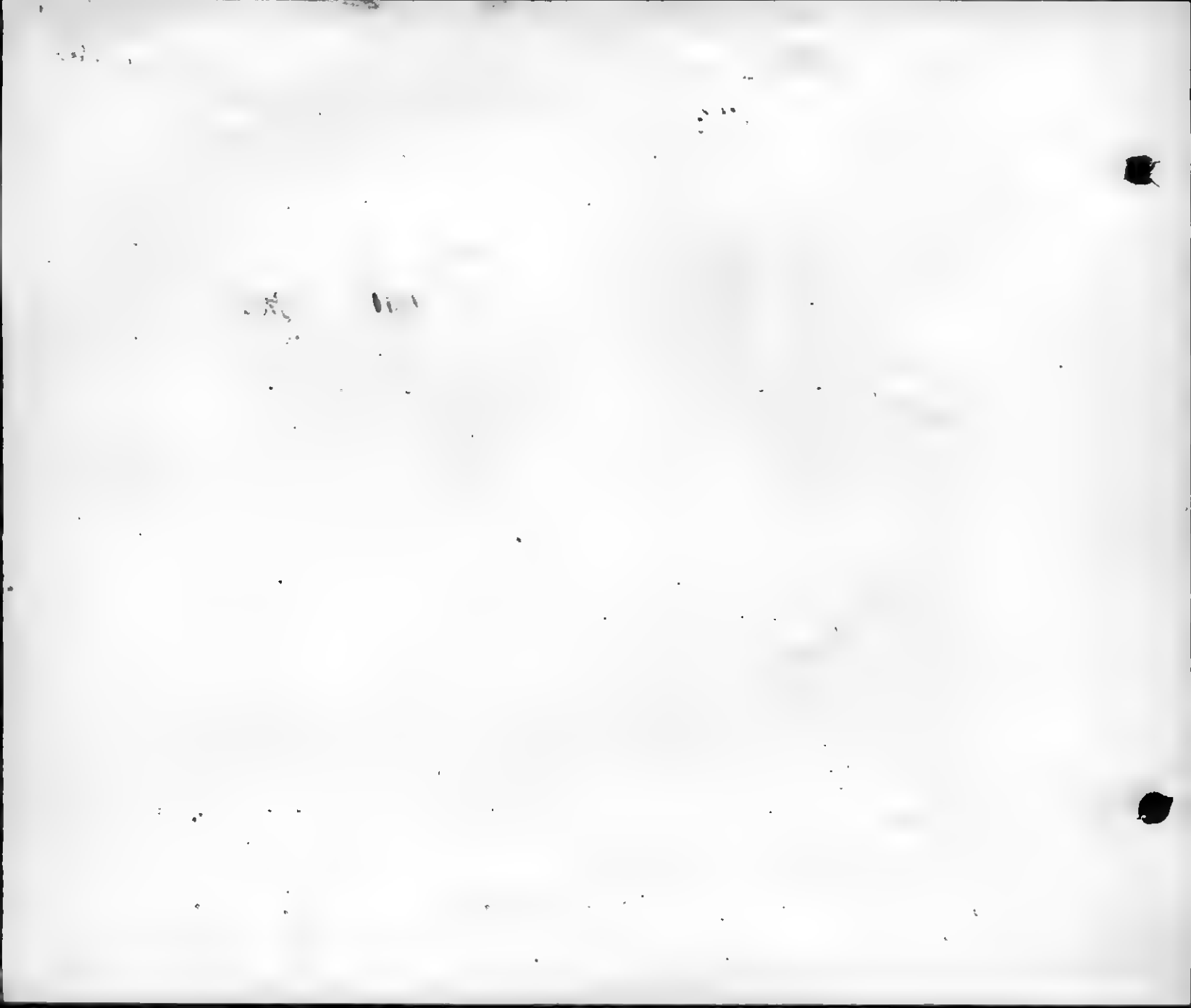
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Crownsville</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>6/15/59</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>1511 W. Lawrence St</u>			
3. NAME OF DECEASED (Type or print) First <u>Maries</u> Middle <u>—</u> Last <u>PRATT</u>				4. DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/18/1888</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	IF UNDER 24 HRS Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE PRATT</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>		INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH. [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>024X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>lypnotatic pneumonia</u> (c) <u>Hypertensive cardi's vascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C. N. S. - Syphilis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>months</u> <u>few days</u> <u>long duration</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/15/59</u> to <u>8/28/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/28/59</u> , 19 <u>59</u> , and that death occurred at <u>5:10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>SEP 3 1959</u>			
PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>				ADDRESS (Street, city or town, state) <u>CROWNVILLE STATE HOSPITAL</u>			
22a. BURIAL, CREMAT. OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 3 - 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Heavenly Bodies</u>		22d. LOCATION (City, town, or county) (State) <u>Crownsville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. H. Cook</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





8738

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>A.A.C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MILLERSVILLE</b>		c. LENGTH OF STAY IN lb <b>2 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SANN'S NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LILLIAN LWANA REED</b>		4. DATE OF DEATH Month Day Year <b>AUGUST 14 1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/23/1865</b>
9. AGE (In years lost birthday) <b>93</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NEW YORK</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>WAYNE BLOODGOOD</b>		14. MOTHER'S MAIDEN NAME <b>FROST</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>MARY NEWBERGER</b>		Address <b>MILLERSVILLE, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>General Arterio Sclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>?</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 13, 1959</b> to <b>8/14</b> 1959, that I last saw the deceased alive on <b>Aug. 13</b> , 1959, and that death occurred at <b>5 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gustave H. Faubert</b> M.D.		ADDRESS (Street, city or town, state) <b>Glen Burnie, Md.</b> DATE SIGNED <b>8/14/59</b>	
PHYSICIAN'S NAME (Type) <b>Gustave H. Faubert MD</b>		<b>Glen Burnie, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>August 15, 59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b> ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 17 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Catherine L. K...</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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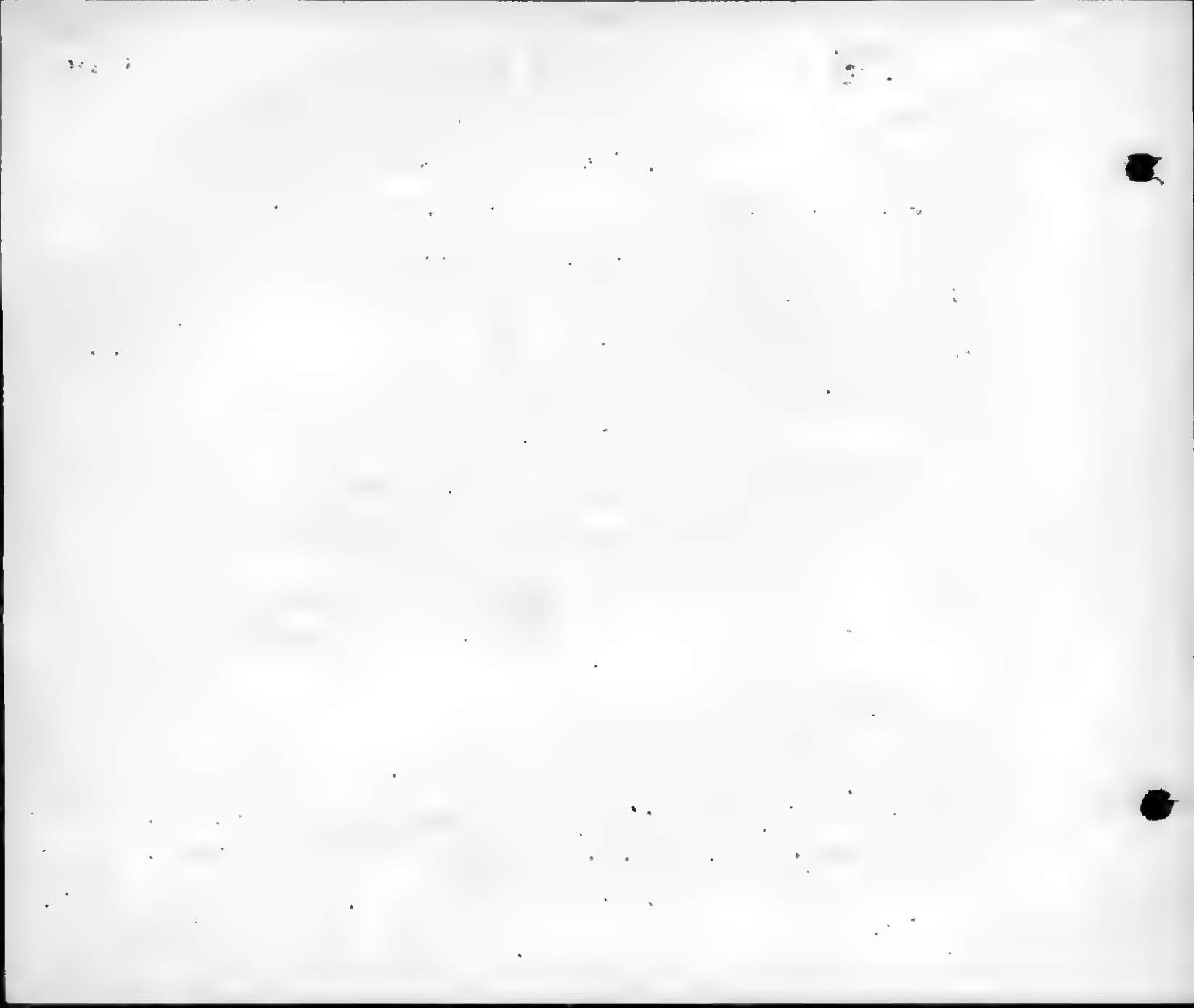
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>1 yr. 1 mo. 13 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Maryland</b> o COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>942 N. Durham Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Robert Daniel Rhynes</b>		4. DATE OF DEATH Month Day Year <b>8 9 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 13, 1884</b>
9. AGE (In years last birthday) yrs <b>75</b>		10. IF UNDER 1 YEAR: Months Days Hours Min. <b>75</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joe Mack Rhynes</b>		14. MOTHER'S MAIDEN NAME <b>Eliza</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-03-6276</b>	
17. MEDICAL CERTIFICATION 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction - Hypostatic Pneumonia</b> <b>120.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hernioplasty - Incisional Electrolyte Imbalance - Post Surgical</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from <b>6/26</b> , 19 <b>58</b> , to <b>8/9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/9</b> , 19 <b>59</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Lionel McHenry Mapp, M.D.</b> <b>Crownsville State Hospital, Md.</b> <b>8/10/59</b> PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M.D.</b> <b>Crownsville State Hospital, Md.</b> <b>8/10/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Aug 14-59</b>		22b. DATE THEREOF <b>Aug 14-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Ignace Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>P/5 Cemetery, Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Kraus</b>		24a. RECEIVED BY REGISTRAR <b>AUG 17 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

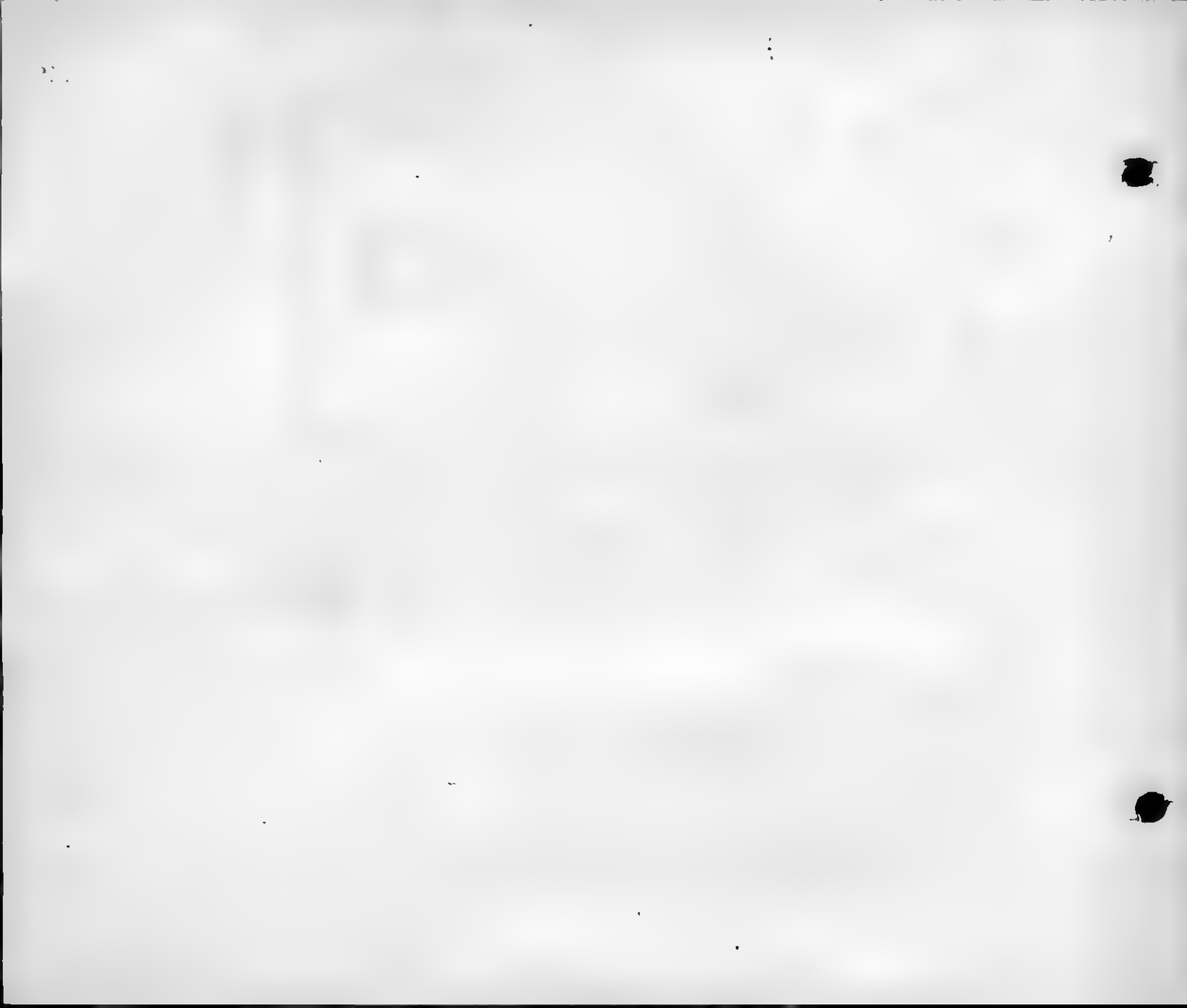
8742

## CERTIFICATE OF DEATH

08707

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shady Side</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shady Side</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>BEDRIC F Riggs</u>		4. DATE OF DEATH <u>Aug 18 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Can</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 1, 1908</u>
9. AGE (In years last birthday) <u>51</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fire Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Walter Reed Hosp</u>	
11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>McCrae Riggs</u>		14. MOTHER'S MAIDEN NAME <u>Deanie Martin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes 10-18-29 8-20-34</u>		16. SOCIAL SECURITY NO. <u>218-12-6450</u>	
17. INFORMANT <u>Mrs Mildred Riggs</u>		Address <u>Shady Side Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1, 1959</u> to <u>Aug 18, 1959</u> , that I last saw the deceased alive on <u>Aug 17, 1959</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>Shady Side, Md.</u> DATE SIGNED <u>8/19/59</u>	
PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-20-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u> ADDRESS <u>Co Line Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 20 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kiana</u>



8739

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

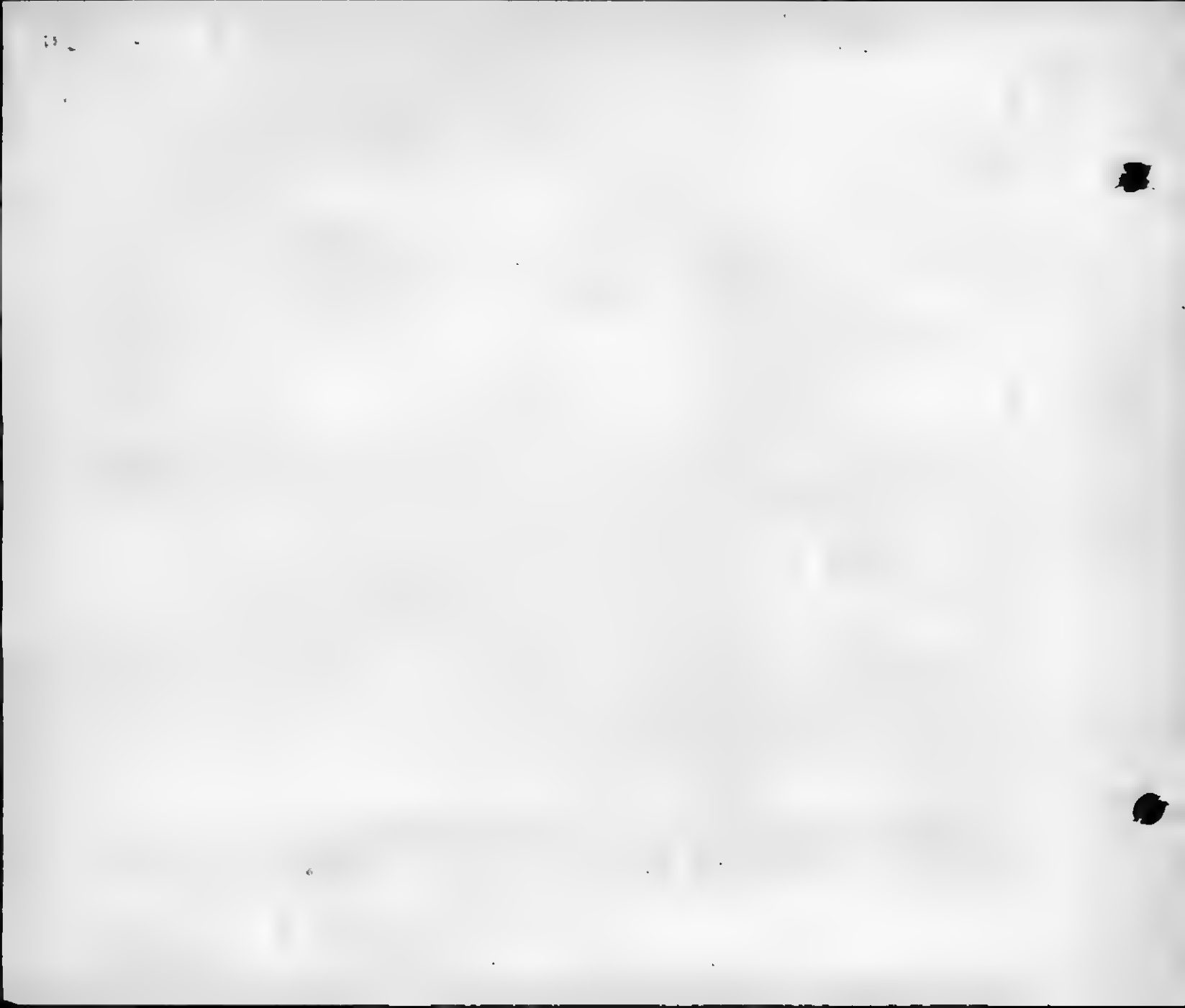
08703

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>A.A.C.O.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admittance on) a. STATE <u>MD</u> b. COUNTY <u>AA CO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenburnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenburnie - MD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>154 Louise Terrace</u>		d. STREET ADDRESS <u>LOUISE TERRACE #154</u>	
3. NAME OF DECEASED (Type or print) <u>Charles M. Riley</u>		4. DATE OF DEATH <u>8 25 19 59</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 April 1915</u>
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>229 09-2287</u>	
11. BIRTHPLACE (State or foreign country) <u>Wilder, Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Riley</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Blackburn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>229-09-2287</u>	
17. INFORMANT <u>Charles</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Artery</u> Conditions, if any, which gave rise to immediate cause (b) <u>under</u> (c) <u>stating the underlying cause lost.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>under</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Charles</u>		DATE SIGNED <u>8/29/59</u>	
EXAMINER'S NAME (Type) <u>F. L. INHAKA</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1 Sept-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. PK</u>	22d. LOCATION (City, town, or county) (State) <u>Howard Co., Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. T. Singleton</u>		24a. REC'D BY REGISTRAR <u>SEP 1 '59</u> 24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





**8740**

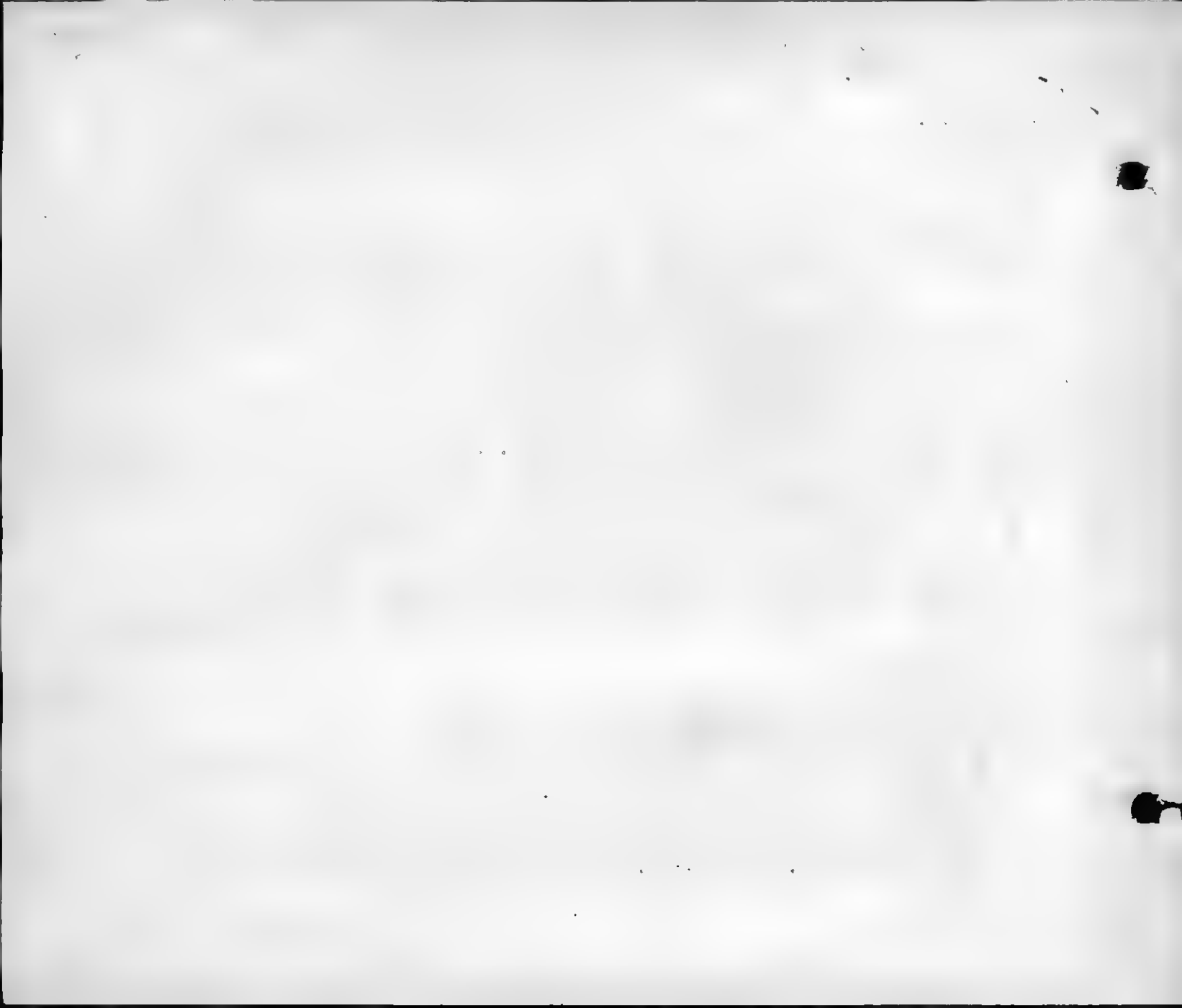
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**08704**

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>A.A.</u> <u>MARYLAND</u>		2 USUAL RESIDENCE (Where deceased lived. If inst. tuition Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
c. LENGTH OF STAY IN 1b <u>2 weeks</u>		d. STREET ADDRESS <u>Same</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>708 Delmar Avenue</u>		e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Silas Nathan Ringler</u>		4. DATE OF DEATH Month <u>August</u> Day <u>18th.</u> Year <u>19 59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/21/1908</u>
9. AGE (in years last birthday) <u>51</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor in High School</u>	11. BIRTHPLACE (State or foreign country) <u>Hollidaysburg, Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James Valentine Ringler</u>	
14. MOTHER'S MAIDEN NAME <u>Clara Virginia Mc Ginnis</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>162-12-7404</u>		17. INFORMANT <u>Mrs. S. N. Ringler (Wife)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4-11</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>p. m.</u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		DATE SIGNED <u>8/18/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>21 Aug-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MacIntire Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Catfish, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard J. Beigelson</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 24 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

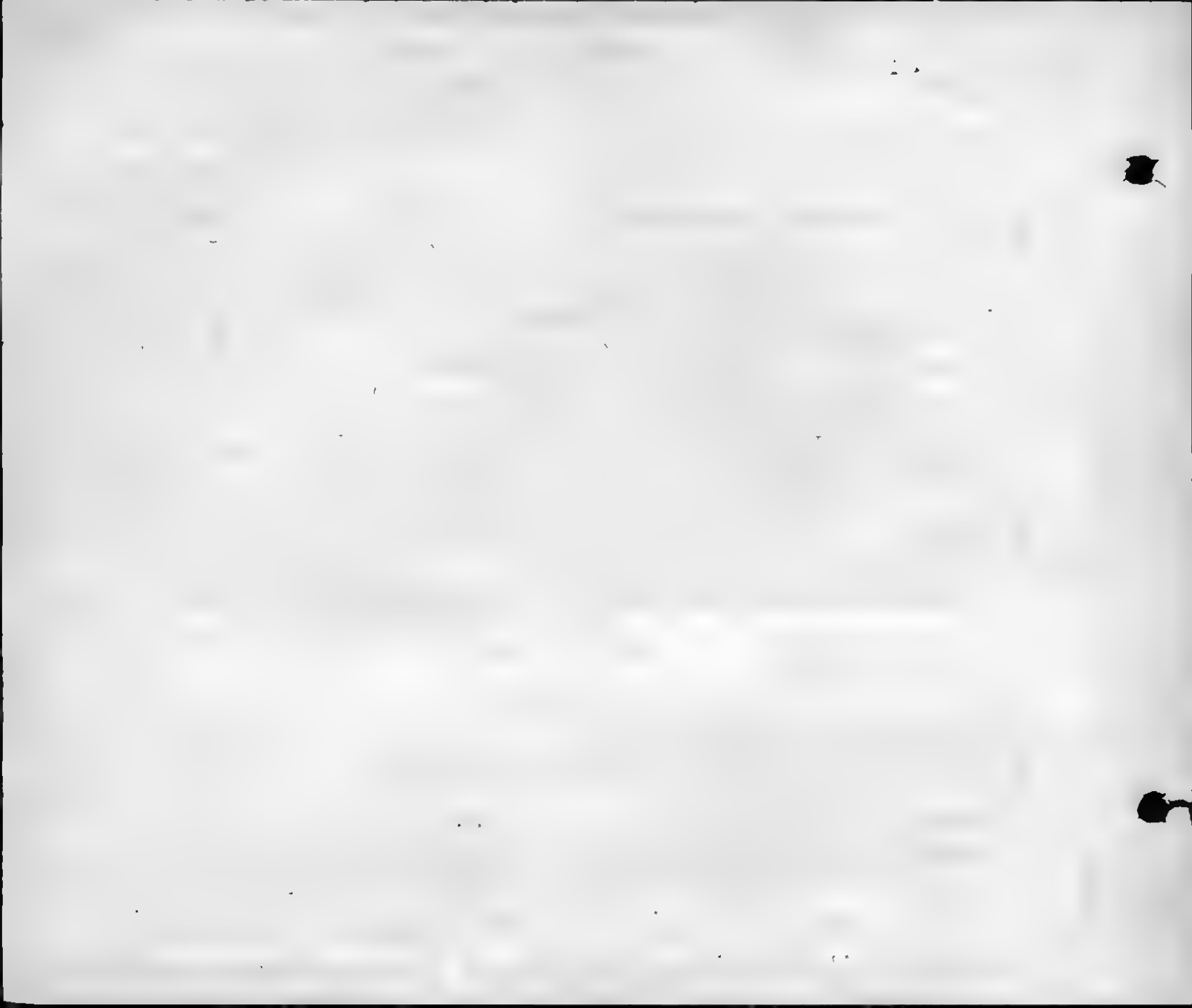
8683

## CERTIFICATE OF DEATH

08705

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		c. LENGTH OF STAY IN 1b <b>1 YEAR</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. NAVAL HOSPITAL</b>		d. STREET ADDRESS <b>9 PORTER ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>FRANKLIN</b> Middle <b>STEARNS</b> Last <b>RIXEY</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>9</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 JUNE 1915</b>
9. AGE (In years last birthday) <b>44</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. NAVY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. NAVY</b>	
11. BIRTHPLACE (State or foreign country) <b>NICARAGUA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>PRESLEY M. RIXEY</b>		14. MOTHER'S MAIDEN NAME <b>LILLIAN T. STEARNS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give year or dates of service) <b>1937 TO PRESENT</b>		16. SOCIAL SECURITY NO. <b>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.</b>	
17. INFORMANT <b>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SUB-ARACHNOID HEMORRHAGE</b> <b>330 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>RUPTURE OF BERRY ANEURISM, CIRCLE OF WILLIS</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>12 HOURS</b> <b>12 HOURS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1100 8-9-</b> , 19 <b>59</b> , to <b>8-9-</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8-9-</b> , 19 <b>59</b> , and that death occurred at <b>9:05 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. NAVAL HOSPITAL</b> DATE SIGNED			
ACTUAL SIGNATURE <b>R. C. LANING</b> PHYSICIAN'S NAME (Type)		M.D. <b>U.S. NAVAL HOSPITAL</b> <b>ANNAPOLIS, MARYLAND</b> <b>10 August 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8-12-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>U.S. Naval Academy Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>		ADDRESS <b>24a. REC'D BY REGISTRAR</b> <b>DATE AUG 12 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur P. House</b>			



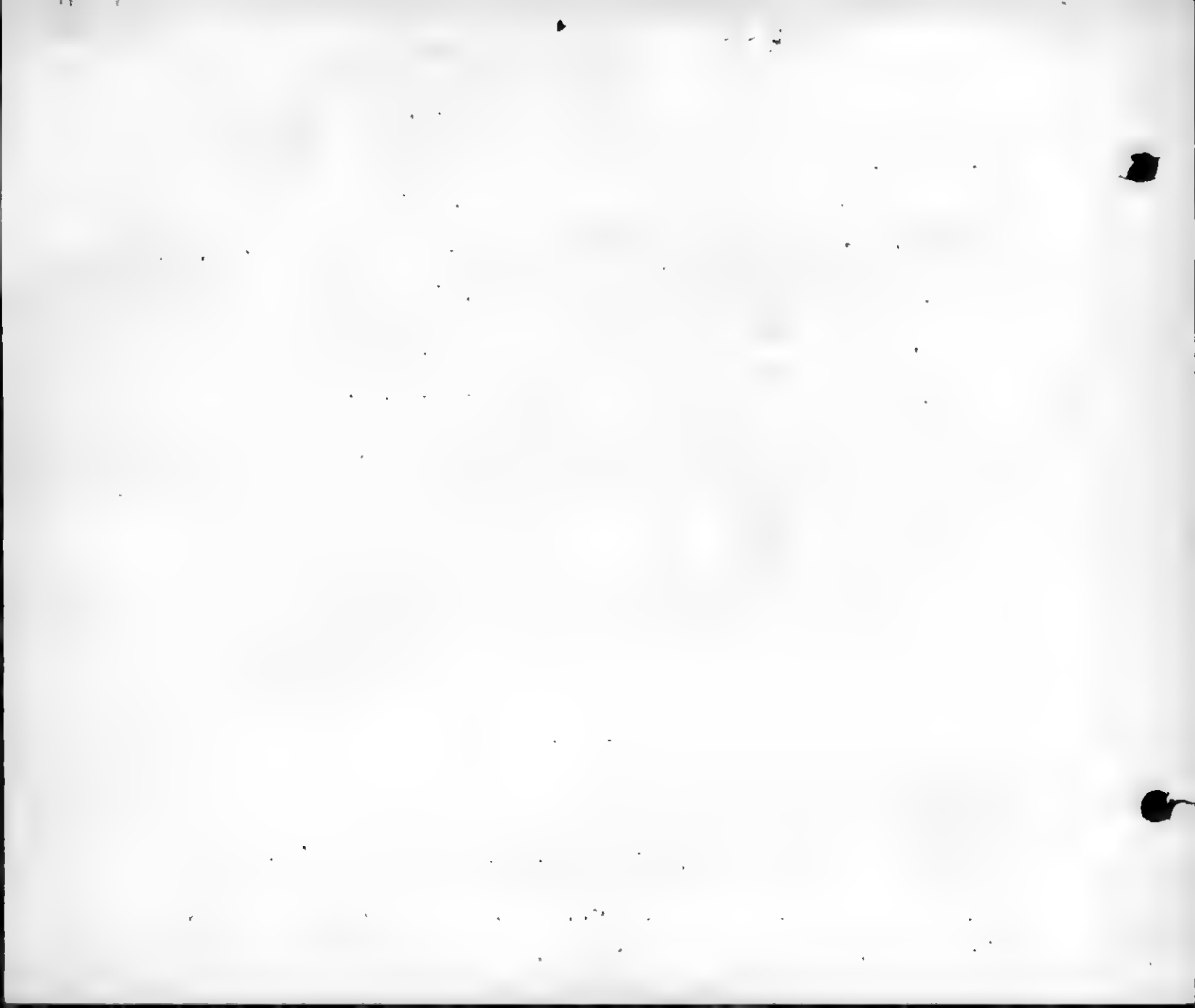
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**8743**  
**CERTIFICATE OF DEATH**

08708

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float:right">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> <span style="float:right">b. COUNTY <u>Anne Arundel</u></span>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bay Head</u>			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bay Head</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bay Head</u>				d. STREET ADDRESS <u>1 Bay Head</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>MARGARET A. RUCK</u>				<b>4. DATE OF DEATH</b> Month <u>Aug.</u> Day <u>26</u> Year <u>1959</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/19/1872</u>		9. AGE (In years last birthday) <u>86</u> yrs.	
						IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS: Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Baier</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Young</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. 		INFORMANT <u>Mrs Genevieve Snow</u>		Address <u>same</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lymphosarcoma</u> <u>200.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <u>8/24</u> 19 <u>59</u> , to <u>8/26</u> 19 <u>59</u> , that I last saw the deceased alive on <u>8/25</u> 19 <u>59</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Leif A. Peeler</u> M.D.				ADDRESS (Street, city or town, state) <u>121 Cathedral St</u>				DATE SIGNED <u>8/26/59</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u> (Annapolis, Md)									
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>			22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard G. Ruck</u>				ADDRESS <u>5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 28 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur A. Thayer</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



8744

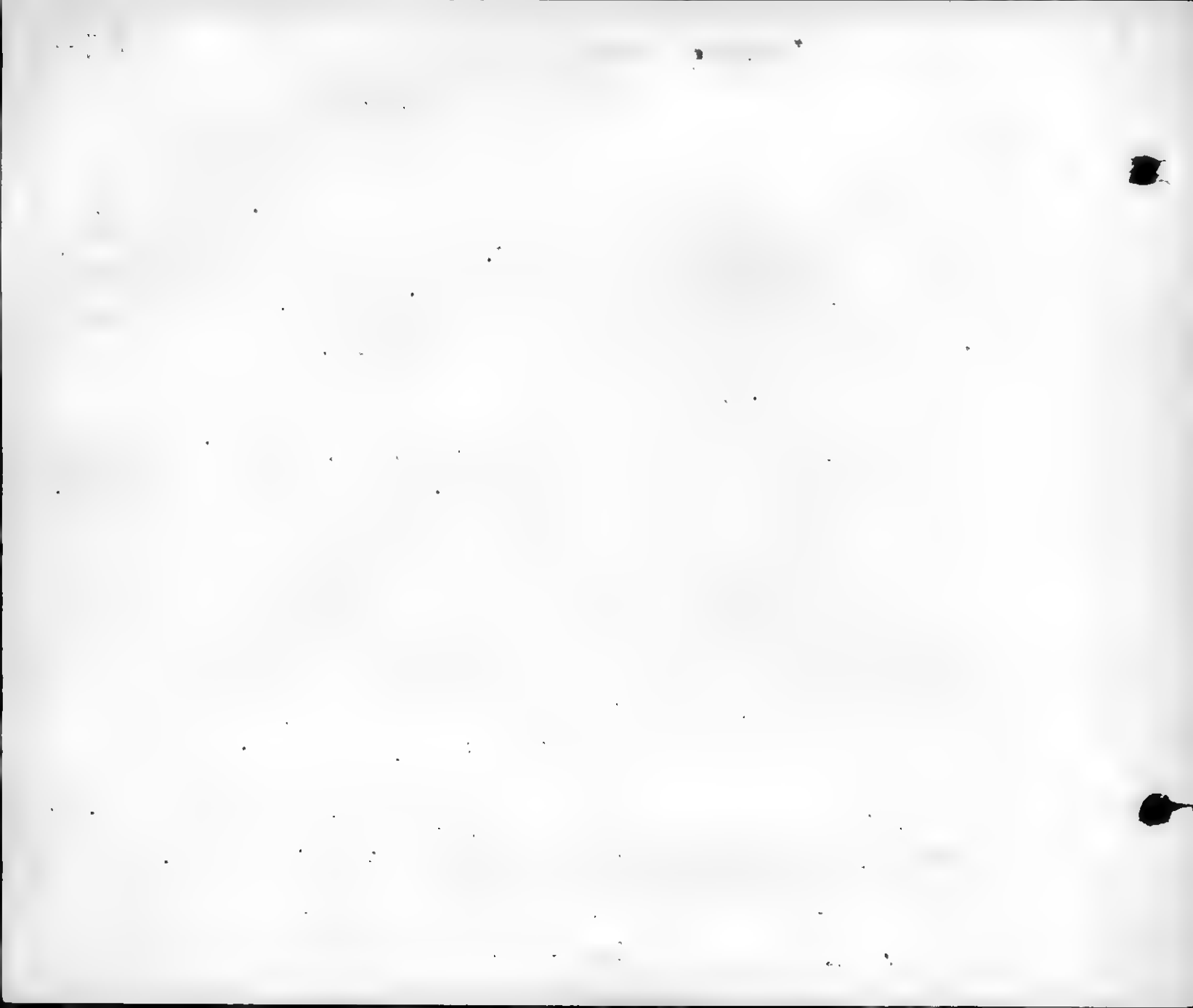
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>AA</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>AA</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linthicum</b>			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1420 W. NURSERY Rd</b>			d. STREET ADDRESS <b>1420 W. NURSERY Rd</b>		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle Last <b>SACHS</b>			4. DATE OF DEATH Month <b>8</b> - Day <b>5</b> - Year <b>1959</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-7-87</b>		9. AGE (In years last birthday) <b>71</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>George SACHS</b>			14. MOTHER'S MAIDEN NAME <b>—</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	INFORMANT <b>Family</b> Address <b>1500 W. NURSERY Rd.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> <b>many years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>—</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>	
20f. (City or town) <b>—</b>		20g. (County) <b>—</b>		20h. (State) <b>—</b>	
21. I certify that I attended the deceased from <b>Oct. 29, 1958</b> to <b>August 5, 1959</b> that I lost s/he the deceased alive on <b>Aug. 5, 1959</b> and that death occurred at <b>4:15 PM</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Florian P Nadolski</b>		M.D. <b>2703 Hainmond Perry Rd</b>		DATE SIGNED <b>8/6/59</b>	
PHYSICIAN'S NAME (Type) <b>Florian P Nadolski</b>		<b>Baltimore 27, Md</b>			
22a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8-8-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>	
22d. LOCATION (City, town, or county) <b>BROOKLYN, MD.</b>		22e. (State) <b>—</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Home 130 E Fort Ave.</b>			ADDRESS <b>—</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 10 '59</b>
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8745 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08710

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>14 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wilson Rd. 1209</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Irving C. Sanford</u> First Middle Last		4. DATE OF DEATH Month Day Year <u>August 2 1959</u> 19	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/2/85</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-07-6180</u>	
17. INFORMANT <u>Harry R. Sanford (son)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8/2/59</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>8-6-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 4 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles L. Hume</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

8746

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

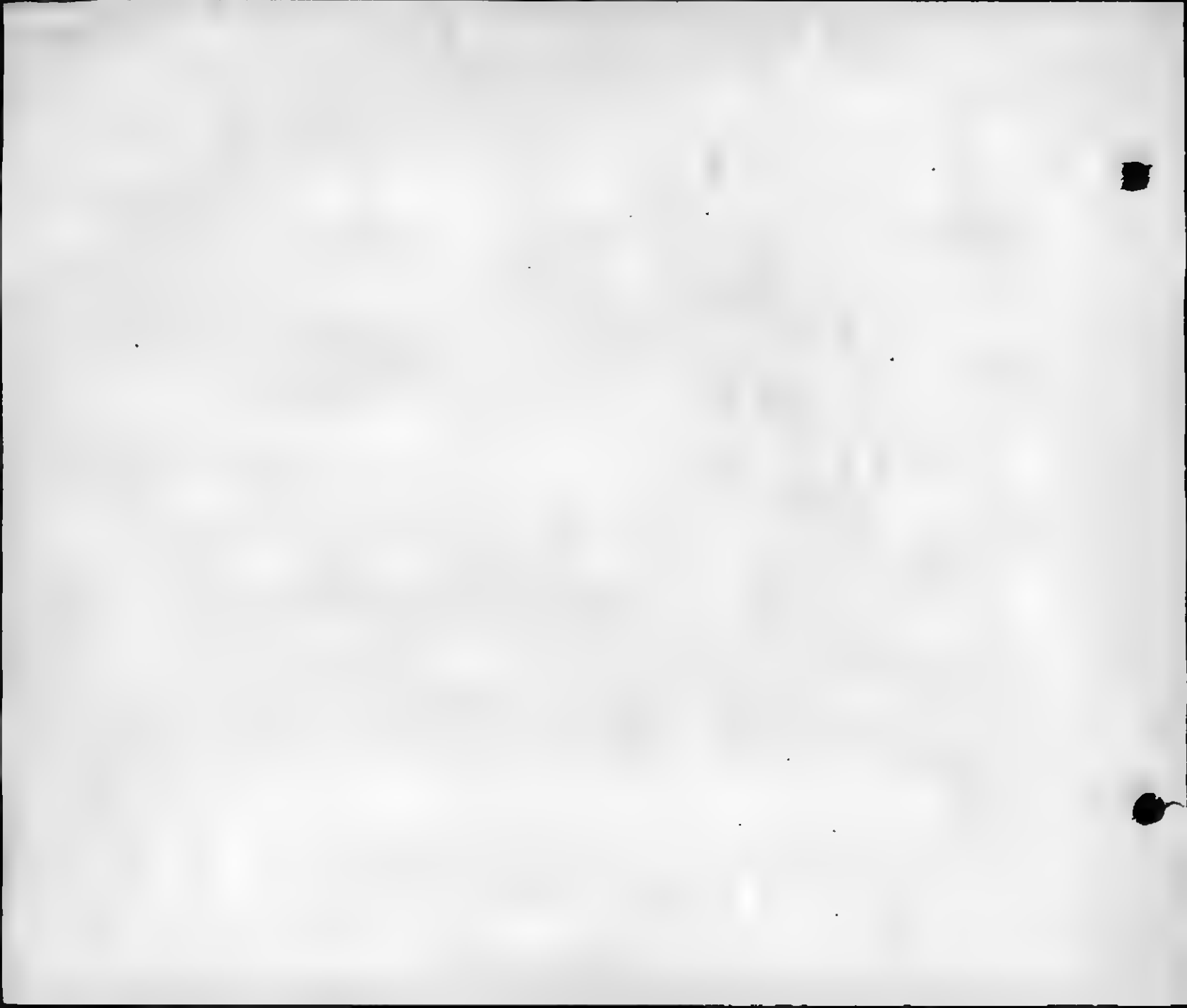
Item 7 Film 248 9-3-59 at

08711

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTPORT</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTPORT</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>123 BOYSHORE DRIVE</u>		d. STREET ADDRESS <u>123 Boyshore Drive</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First Middle Last		4. DATE OF DEATH Month <u>Aug</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12-1889</u>
9. AGE (in years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Industry</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WMADE. H. SEARS</u>		14. MOTHER'S MAIDEN NAME <u>LEMA Hartge</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-16-8418</u>	
17. INFORMANT <u>John A. SEARS - k. - Hammonds Ferry Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>Sudden</u> (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. LINHARDT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/31/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK</u>		22d. LOCATION (City, town, or county) (State) <u>WOODLAWN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Phillips - Woodlawn Rd</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 31 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kinn</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



8631

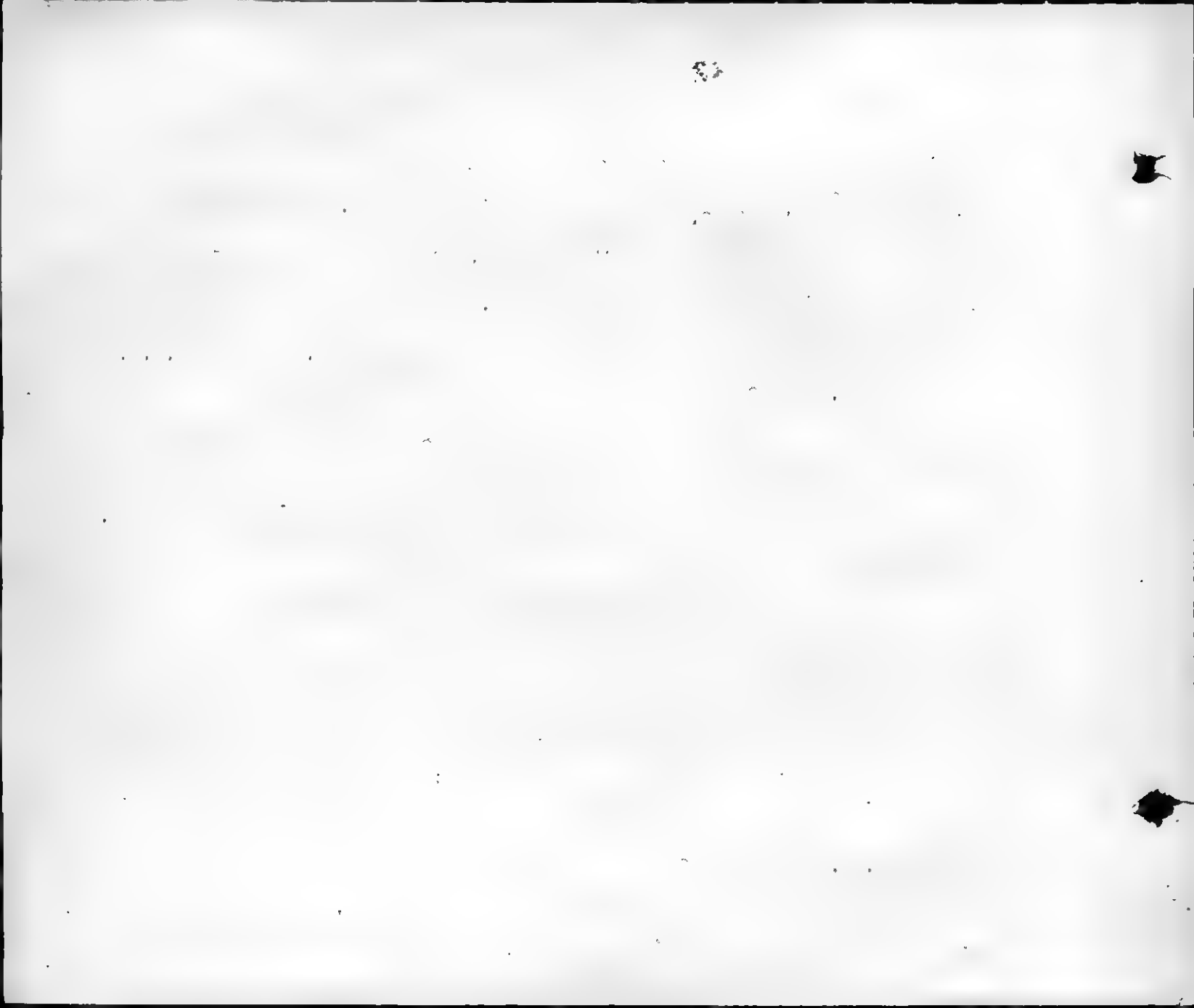
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>13 DAYS</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA VALE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <b>116 PARK AVE. PARK HEIGHTS</b>	
3 NAME OF DECEASED (Type or print) First <b>DOROTHY</b> Middle <b>W</b> Last <b>SHIRES</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>1</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 8 1911</b>	9. AGE (In years last birthday) yrs. <b>47</b>	IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>THOMAS A. SHIRES</b>		14. MOTHER'S MAIDEN NAME <b>GRACE DEFFINBAUGH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>MEMORIAL HOSPITAL</b> Address <b>CUMBERLAND, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>170X</b> DUE TO <b>Metastatic Carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>carcinoma of breast</b> DUE TO (c) <b></b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b> <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>Aug 1 1959</b> to <b>Aug 1 1959</b> that I last saw the deceased alive on <b>Aug 1 1959</b> and that death occurred at <b>2:00 P. M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>W. Royce Hodges</b>		M. D. <b>Cumberland, Md.</b>		DATE SIGNED <b>8/1/59</b>	
PHYSICIAN'S NAME (Type) <b>DR. W. ROYCE HODGES</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/4/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cem.</b>	
22d. LOCATION (City, town, or county) (State) <b>Cumberland Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Steu Inc</b>		ADDRESS <b>Cumb-Md</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 4 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>					

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove center papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

8684

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film 0247 8-31-59 et

08712

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA CO</u> b. CITY OR TOWN (If outside corporate limits, write R.U.R.A. and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.M. ANNE ARUNDEL GENERAL</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA CO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Leveigh Wtts - MD</u> d. STREET ADDRESS <u>Bumpers Hole - Road.</u> e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>SILER</u> Last 4. DATE OF DEATH Month <u>8</u> Day <u>21</u> Year <u>1959</u>		5. SEX <u>F</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 31 1900</u> 9. AGE (In years with day) <u>58</u> 10. IF UNDER 1 YEAR Months <u>1</u> Days <u>21</u> 11. IF UNDER 24 HRS. Hours <u>1</u> M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u> 11. BIRTHPLACE (State or foreign country) <u>Dublin Co. N.C.</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Linon Teacher</u> 14. MOTHER'S MAIDEN NAME <u>Cadelia Whitehead</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>Johnson Whitehead</u> 17. INFORMANT Address <u>Baltimore</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary disease</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Sudden</u> (a), stating the underlying cause last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> EXAMINER'S NAME (Type) <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>9/24/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Aug. 25/59</u> 22b. DATE THEREOF <u>Mt. Calvary</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u> 22d. LOCATION (City, town, or county) (State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>J.B. Johnson</u> ADDRESS <u>Annapolis</u> 24a. REC'D BY REGISTRAR DATE <u>AUG 26 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>	

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

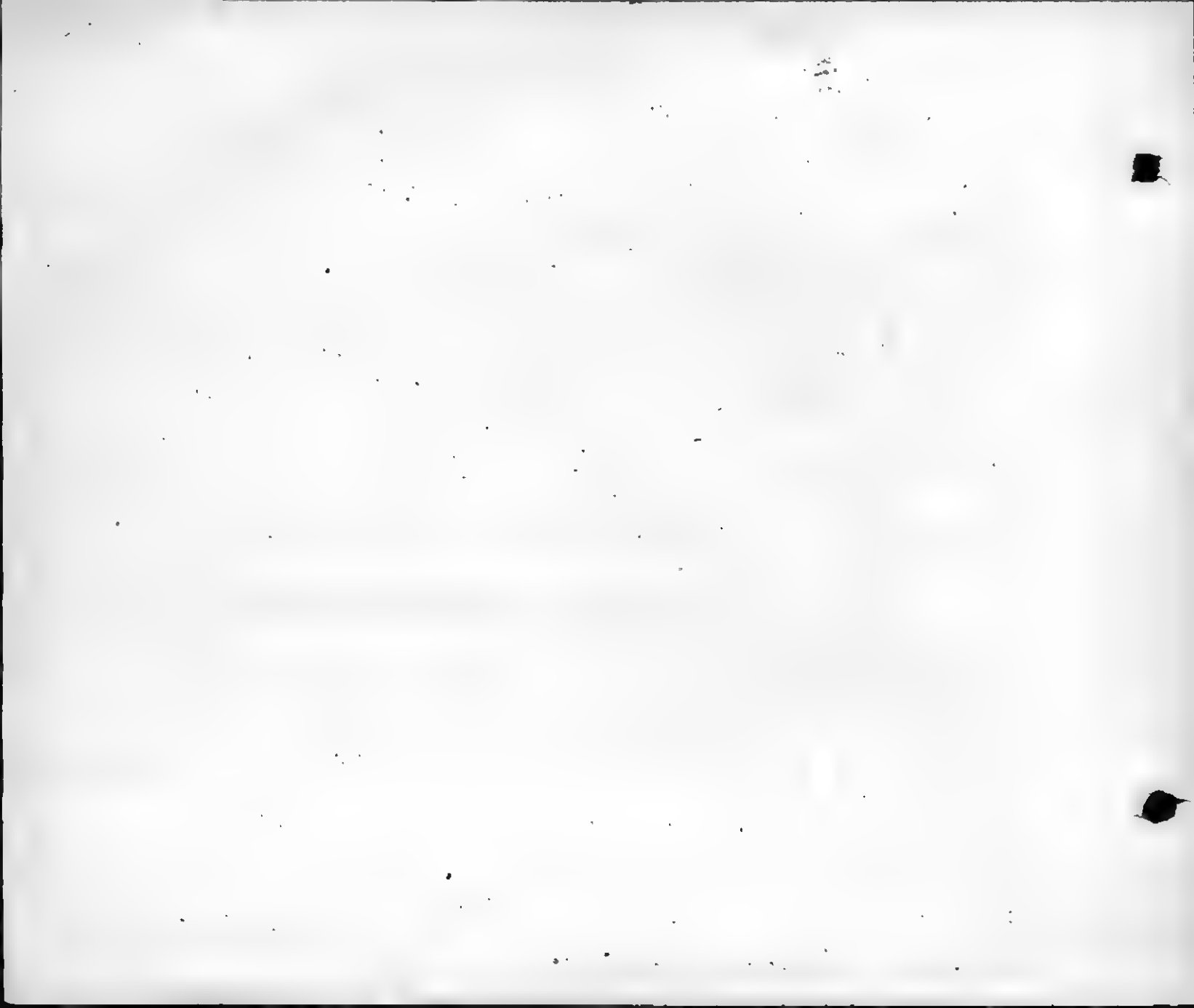




Reg. Dist. No.

MEDICAL CERTIFICATION

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

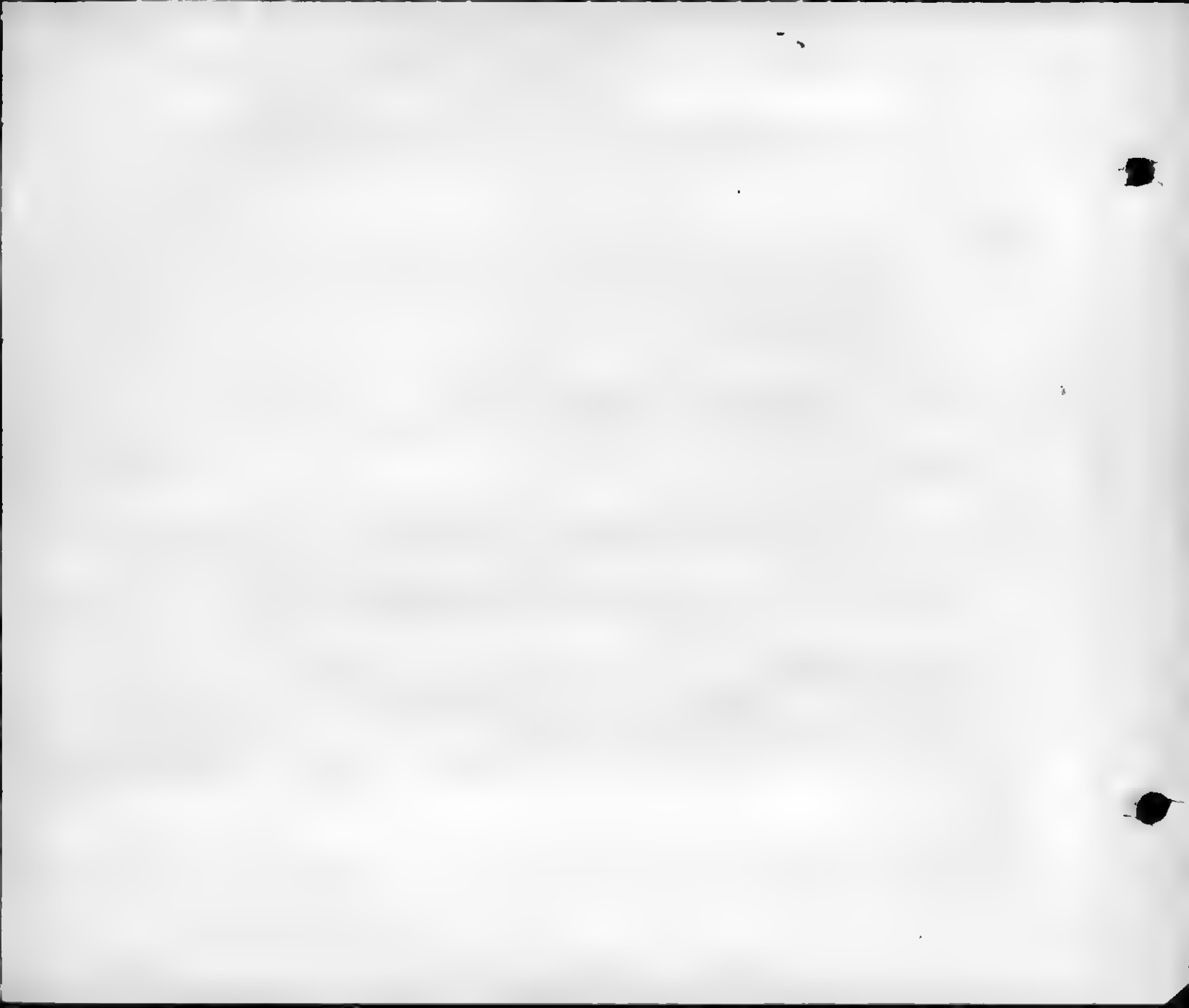
08714

8747

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - SOLLEY</u>				c. LENGTH OF STAY IN 1b <u>1 YEAR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - SOLLEY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>123 MARLEY WICK ROAD</u>				d. STREET ADDRESS <u>123 MARLEY WICK ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES BURTON SMITH</u>				4. DATE OF DEATH Month Day Year <u>AUG. 22 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 2, 1916</u>	
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>CHARLES HENRY SMITH</u>				14. MOTHER'S MAIDEN NAME <u>GRACE MAY BURTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>JULY-OCT. 1945 212-14-9190</u>		17. INFORMANT <u>Ruth Smith</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRAIN TUMOR WITH METASTASES</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>POOR NUTRITION</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>				20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I attended the deceased from <u>JUNE, 1959</u> , to <u>AUG. 22, 1959</u> , that I last saw the deceased alive on <u>AUG. 22, 1959</u> , and that death occurred at <u>2130A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Brady Smith</u>				ADDRESS (Street, city or town, state) <u>8471 FT. SMALLWOOD ROAD</u>			
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>				DATE SIGNED <u>9/22/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>9.26.59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Haven</u>		22d. LOCATION (City, town, or county) <u>Bethesda</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William - 130 E. Fort Ave</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	



TO HOSPITAL OR DURING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8748

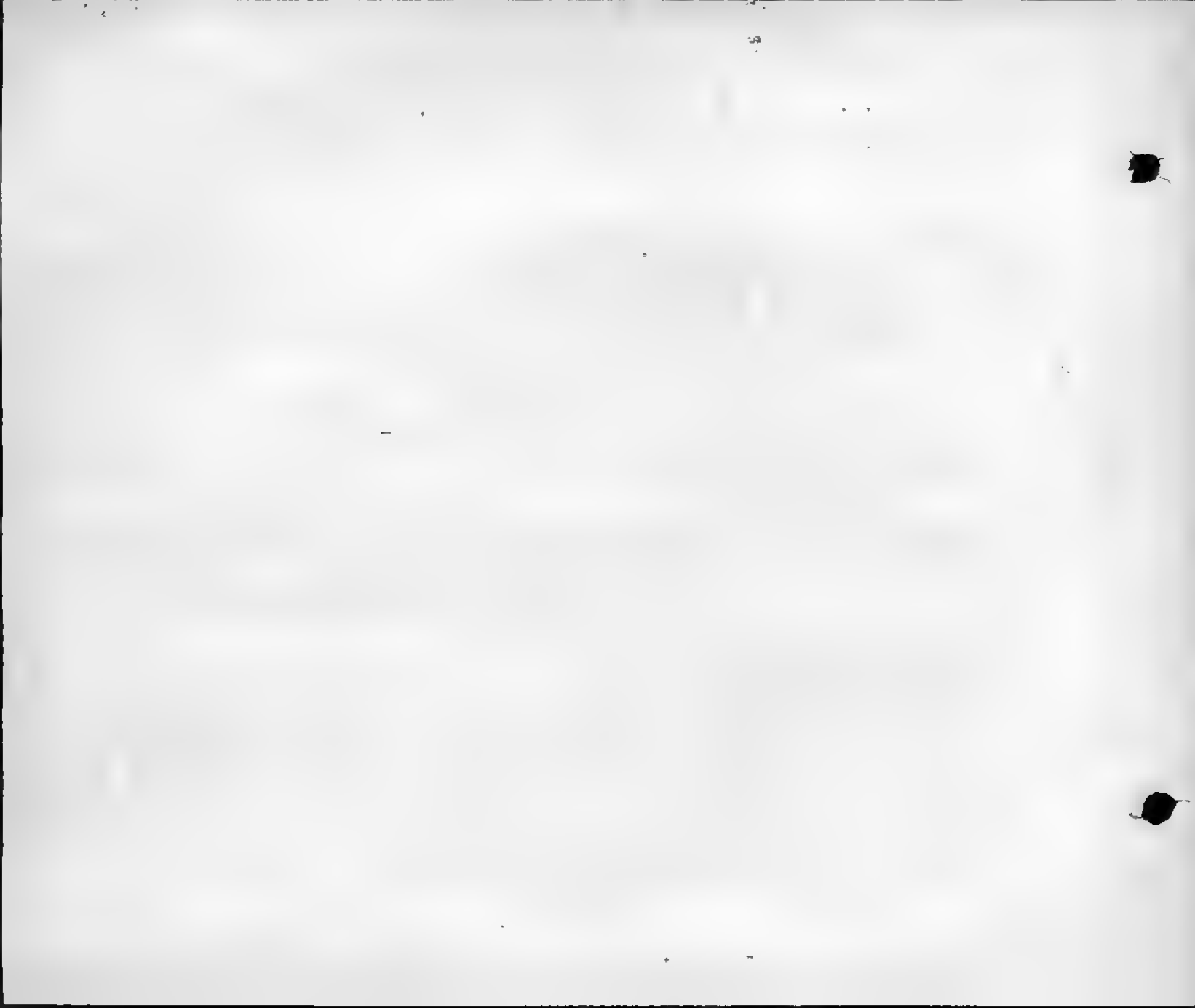
## CERTIFICATE OF DEATH

08716

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>A.A.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>A.A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>114 Meadow Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ISABELLE M.</b> Middle <b>STARR</b> Last		4. DATE OF DEATH <b>8/7/59</b> Month Day Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/23/22</b>
9. AGE (In years last birthday) <b>37</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles Beck</b>		14. MOTHER'S MAIDEN NAME <b>Rose ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Family - Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic carcinoma c. Caecalis</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma of rectum</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6 June 57</b> <b>7 Aug 59</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6 June</b> , 19 <b>57</b> , to <b>7 Aug</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>31 July</b> , 19 <b>59</b> , and that death occurred at <b>3:30 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>4016 Ritchie Hwy</b> DATE SIGNED <b>7 Aug 59</b>			
ACTUAL SIGNATURE <b>Andrew R. Sosnowski</b>		M.D. <b>4016 Ritchie Hwy</b>	
PHYSICIAN'S NAME (Type) <b>Andrew R. Sosnowski</b>		<b>Balto-25-Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>	22b. DATE THEREOF <b>8/10/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Homes - 130 E. Fort Ave</b>		24a. REC'D BY REGISTRAR <b>AUG 11 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Charles E. Kline</b>	

MEDICAL CERTIFICATION



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 0246 8-12-59 et

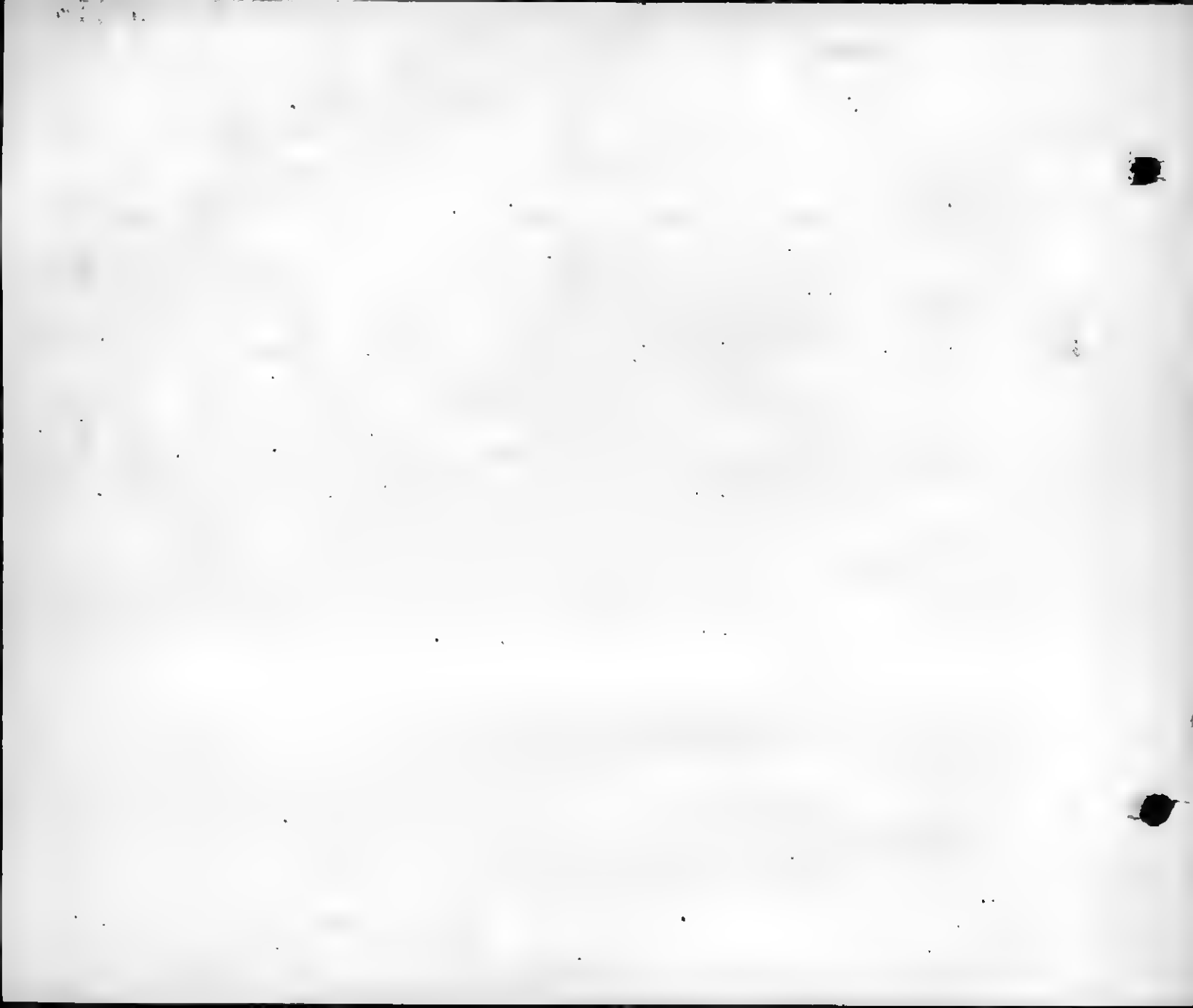
08717

8686

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) o. STATE <i>MARYLAND</i> COUNTY <i>ANNAPOLIS</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ANNAPOLIS</i>				c. LENGTH OF STAY IN 1b <i>NONE</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>ANNAPOLIS GENERAL</i>				d. STREET ADDRESS <i>2212 W. HAMBURG ST.</i>			
3. NAME OF DECEASED (Type or print) <i>Edward</i> First <i>H.</i> Middle <i>Steinbock</i> Last				4. DATE OF DEATH <i>8-1-59</i> Month <i>8</i> Day <i>1</i> Year <i>1959</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Wh.</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1899 OCT 26 1954</i>	
9. AGE (In years last birthday) <i>59</i> yrs.		IF UNDER 1 YEAR Months <i>5</i> Days <i>9</i> Hours <i>59</i> Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Police</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Balti City</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>W. M. Steinbock</i>				14. MOTHER'S MAIDEN NAME <i>LENA HUTH</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>NONE</i>			
17. INFORMANT <i>Wife</i> Address <i>2212 W. HAMBURG ST BALTO</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i> <i>4:30-1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <i>INTERVAL BETWEEN ONSET AND DEATH minutes</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Body Cleared for Removal by Coroner</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>DOA</i> , 19__ to __, 19__, that I last saw the deceased alive on __, 19__, and that death occurred at <i>8:05 PM</i> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <i>121 CATHEDRAL ST</i> DATE SIGNED <i>Richard N. Peeler</i>							
ACTUAL SIGNATURE <i>Richard N. Peeler</i> M.D.							
PHYSICIAN'S NAME (Type) <i>RICHARD N. PEELER</i> <i>ANNAPOLIS, MD</i>							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-1-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Meadow Ridge</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Co Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>McLully Funeral Homes</i> ADDRESS <i>Balti Md</i>				24a. REC'D BY REGISTRAR <i>AUG 7 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Carlton S. Thomas</i>	





8749

## CERTIFICATE OF DEATH

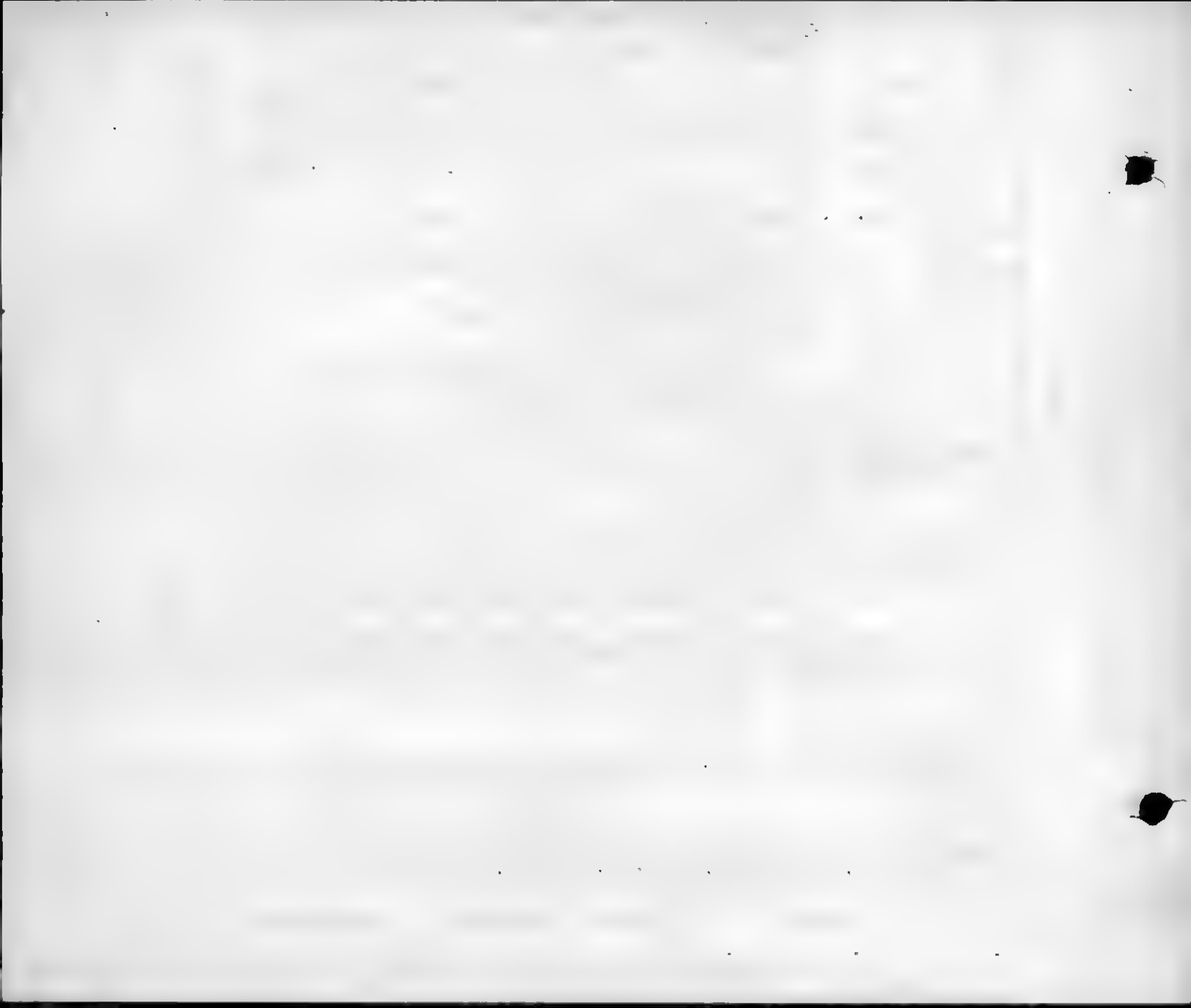
Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crt Geo G. Wade, Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Wade</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				d. STREET ADDRESS <u>453d Butler Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>Harold</u> Last <u>Stoever</u>				4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10 Aug 1959</u>		9. AGE (In years last birthday) yrs. <u>10</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Mins <u>0</u>	IF UNDER 24 HRS Hours <u>0</u> Mins <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>n/a</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>n/a</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Ellsworth Stoever</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Jane Robinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address (Father) <u>Robert E. Stoever, 1538 Juhl r St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Breech delivery at home with retention of head</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs 15 min</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10 August</u> 19 <u>59</u> , to <u>10 August</u> 19 <u>59</u> , that I last saw the deceased alive on <u>10 August</u> 19 <u>59</u> , and that death occurred at <u>2745</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>20 Aug 59</u>							
ACTUAL SIGNATURE <u>W. H. Miller Jr.</u> M.D.				PHYSICIAN'S NAME (Type) <u>U. S. Army Hospital, Ft Geo G. Wade, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-12-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wm Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kemp</u>	

2050374XV3

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



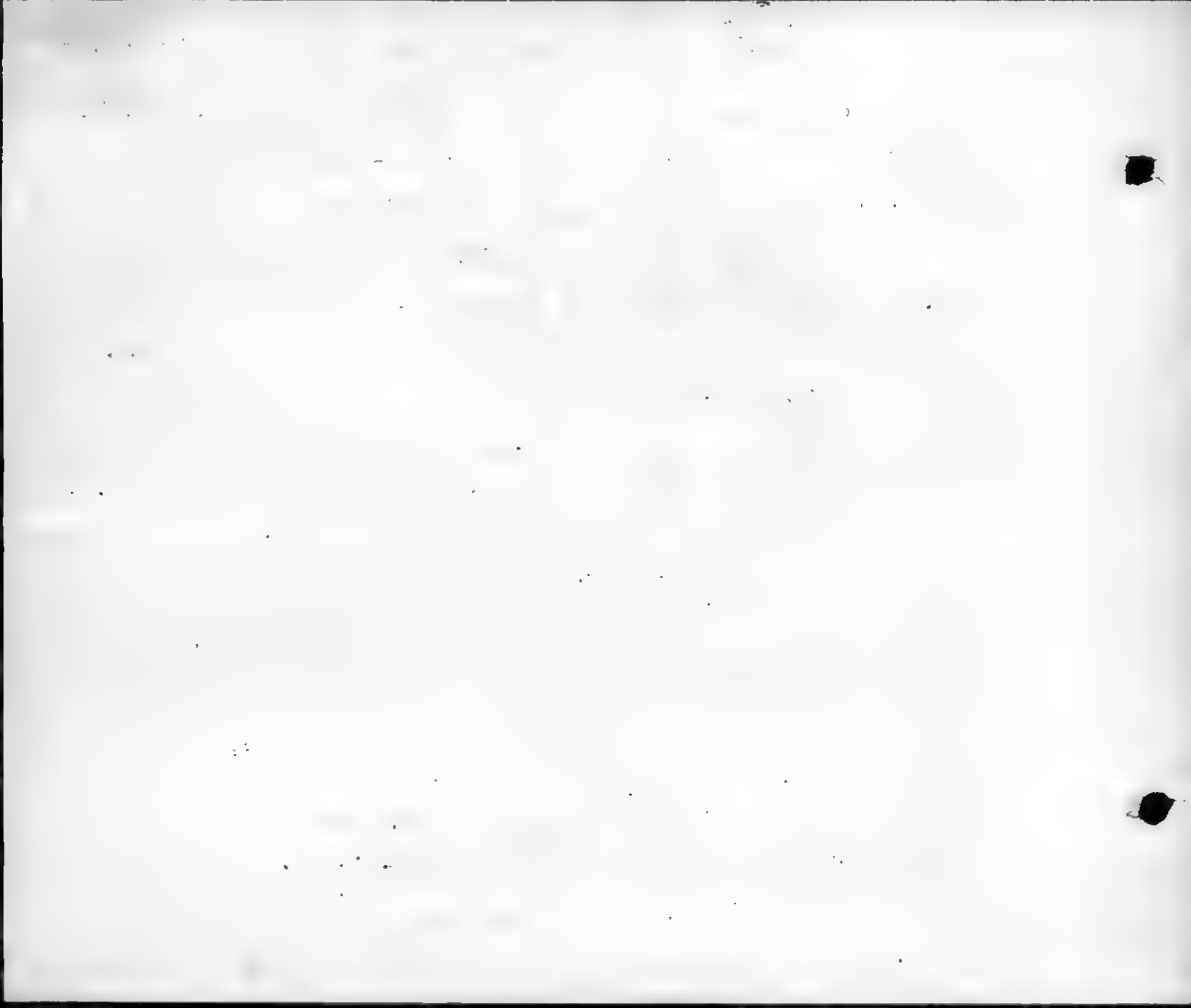
8687

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>10 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. STREET ADDRESS <b>14 Cliff Drive</b>			
3. NAME OF DECEASED (Type or print) First <b>Eva</b> Middle <b>SUITE</b> Last <b>SUITE</b>				4. DATE OF DEATH Month <b>August</b> Day <b>19</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 11, 1890</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min.		IF UNDER 24 HRS Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Eastport Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>THOS COLLISON</b>				14. MOTHER'S MAIDEN NAME <b>Cable</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>James F. Suite MT. RAINIER, MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary failure</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Acute cerebral hemorrhage</b> DUE TO <b>10 days</b> (c) <b>Hypertensive vascular disease</b> DUE TO <b>unknown</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>August 9, 1959</b> to <b>August 18, 1959</b> , that I last saw the deceased alive on <b>August 18, 1959</b> , and that death occurred at <b>3:40 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mayo Road Edgewater, Md.</b> DATE SIGNED <b>8/19/59</b>							
ACTUAL SIGNATURE <b>Sylvia M. Lin</b> M.D.				PHYSICIAN'S NAME (Type) <b>Sylvia Lin</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>8/21/59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Hope Chapel</b>				22d. LOCATION (City, town, or county) (State) <b>Mayo Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard Q. J...</b>				24a. REC'D BY REGISTRAR <b>AUG 24 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>							

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



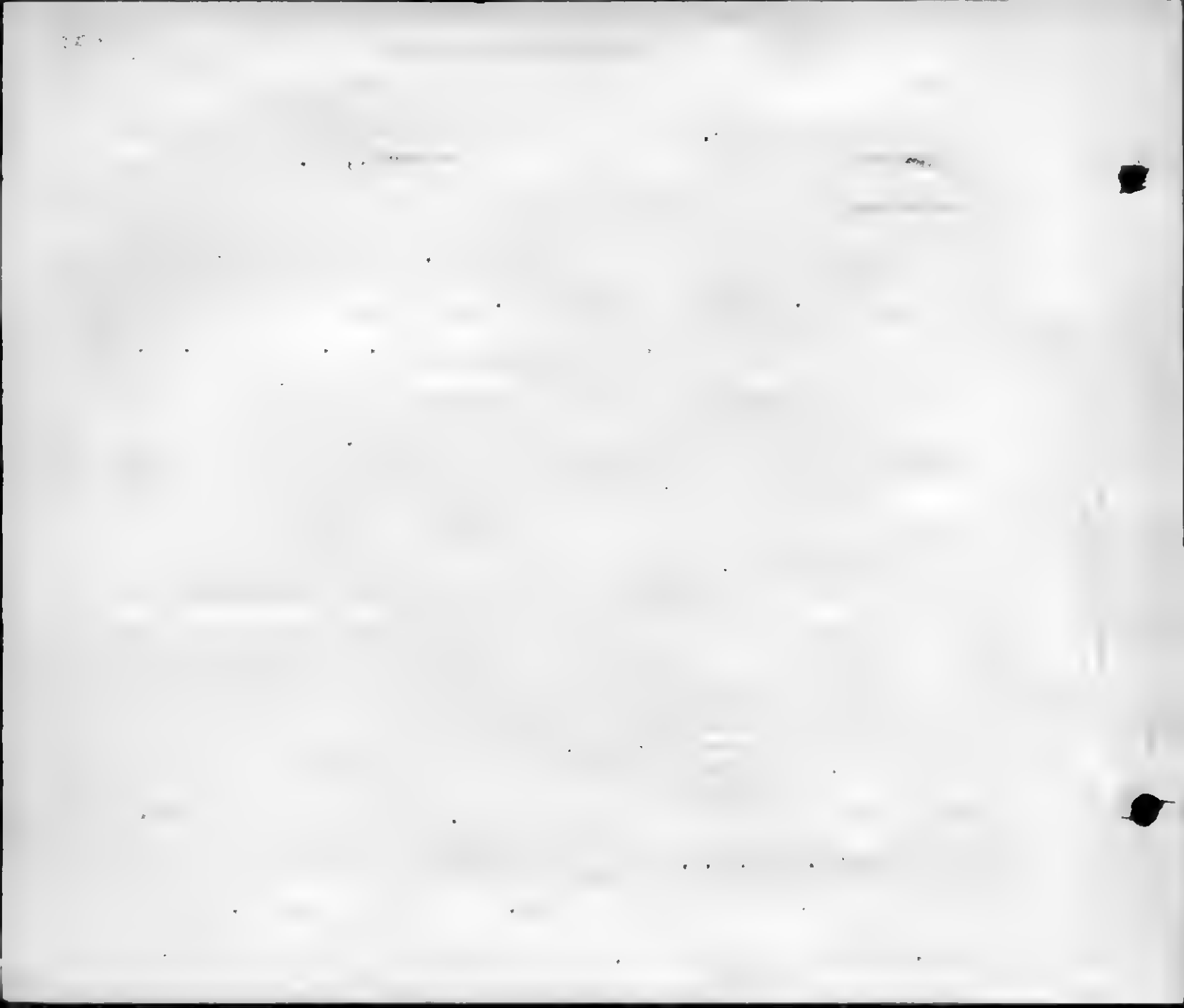
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**8750**  
**CERTIFICATE OF DEATH**

08720

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Arundel</u> <b>ANNE ARUNDEL</b> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Home Inc. Plaza Manor Convalescent</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor Convalescent Home Inc</u>				d. STREET ADDRESS <u>Furnace Branch &amp; Lee Roads</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Joseph</u>		First Middle Last <u>Thompson Sr.</u>		4. DATE OF DEATH Month <u>August</u> Day <u>2nd</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov./22/1888</u>		9. AGE (In years last birthday) <u>70</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>In Gen.</u>		11. BIRTHPLACE (State or foreign country) <u>St Marys Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Belinda Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>Mary Thompson 202 N. Spring Court</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> <u>4118X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Quadraplegia secondary to arthritis cervical spine, cerebral thrombosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o m p. m <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 6,</u> 19 <u>59</u> , to <u>August 2,</u> 19 <u>59</u> , that I last saw the deceased alive on <u>July 18,</u> 19 <u>59</u> , and that death occurred at <u>1</u> A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>James M. Pair</u>		M. D. <u>400 N. Carrollton Avenue</u> <u>Aug. 4, 1959</u>					
PHYSICIAN'S NAME (Type) <u>James M. Pair, M.D.</u>		<u>Baltimore 23, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Eloy O. Wilson</u> ADDRESS <u>1000 Brantley Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. K...</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



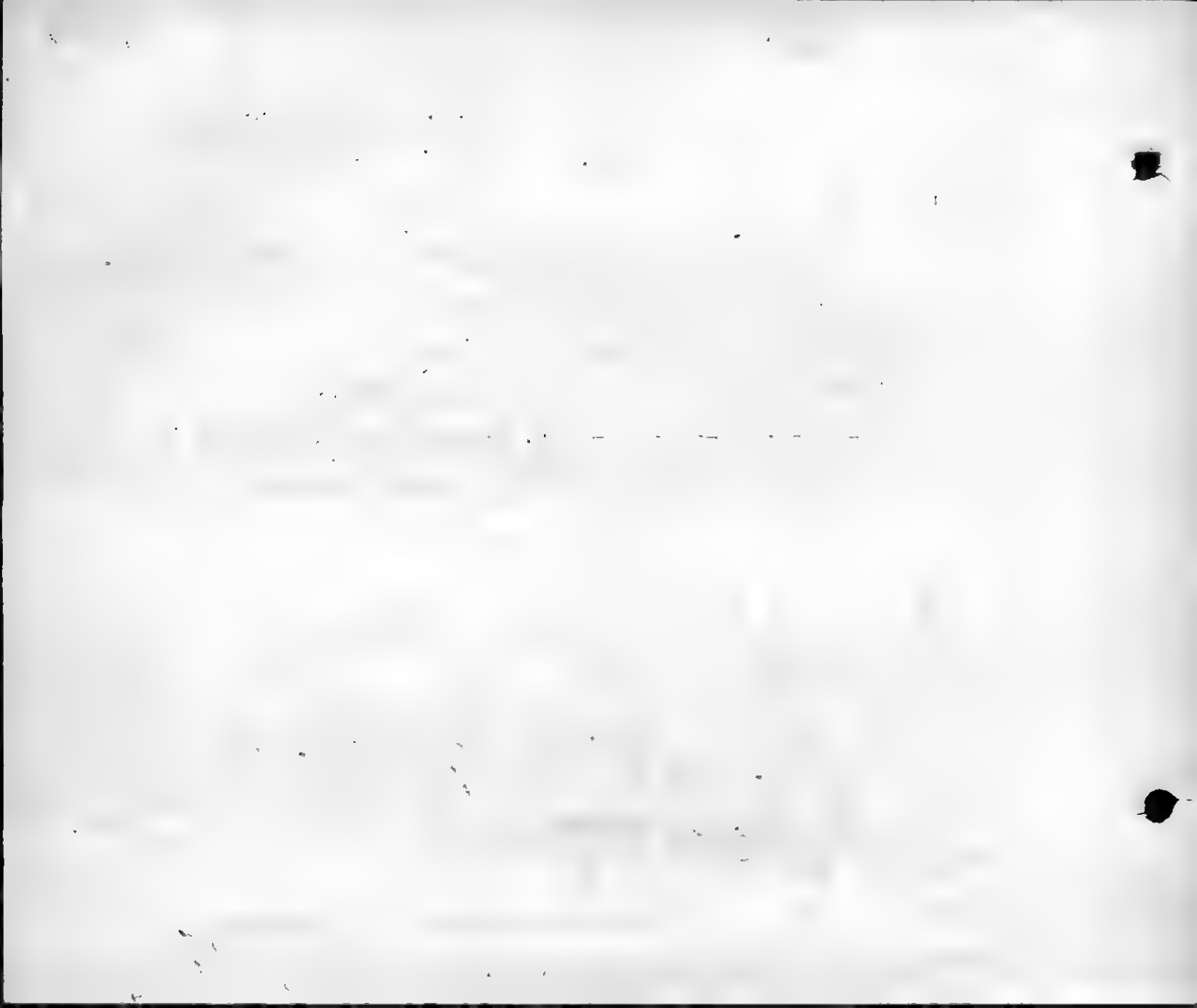
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
8751 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 8 Film G248 9-3-59 et  
CERTIFICATE OF DEATH

08721

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>AA</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville</b>		c. LENGTH OF STAY IN 1b <b>2 mos.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sann's Nursing Home</b>		d. STREET ADDRESS <b>Box 425</b>	
3. NAME OF DECEASED (Type or print) First <b>Naomi</b> Middle Last <b>Ward</b>		4. DATE OF DEATH <b>8/28/59</b> 19 <b>59</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/21/50</b> 1868
9. AGE (in years last birthday) <b>90</b> yrs		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wilson Disney</b>		14. MOTHER'S MAIDEN NAME <b>Angelina Ray</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Mr. Benjamin Ward, same as 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>170 X</b> DUE TO <b>Carcinoma Breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. City or town (County) (State)			
21. I certify that I attended the deceased from <b>April 15 - 59</b> to <b>Aug 29 - 59</b> that I last saw the deceased alive on <b>Aug 8 - 59</b> and that death occurred <b>9:30 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Elkridge, Md</b> DATE SIGNED <b>9/29-59</b>			
ACTUAL SIGNATURE <b>R. JOSEPH LIPSKE, M.D.</b> PHYSICIAN'S NAME (Type) <b>DOENTON, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/31/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial</b>	22d. LOCATION (City, town, or county) (State) <b>Elkridge</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. H. Kirkley</b> ADDRESS <b>Hopping and Kirkley, Glen Burnie, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 31 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krasa</b>





8752

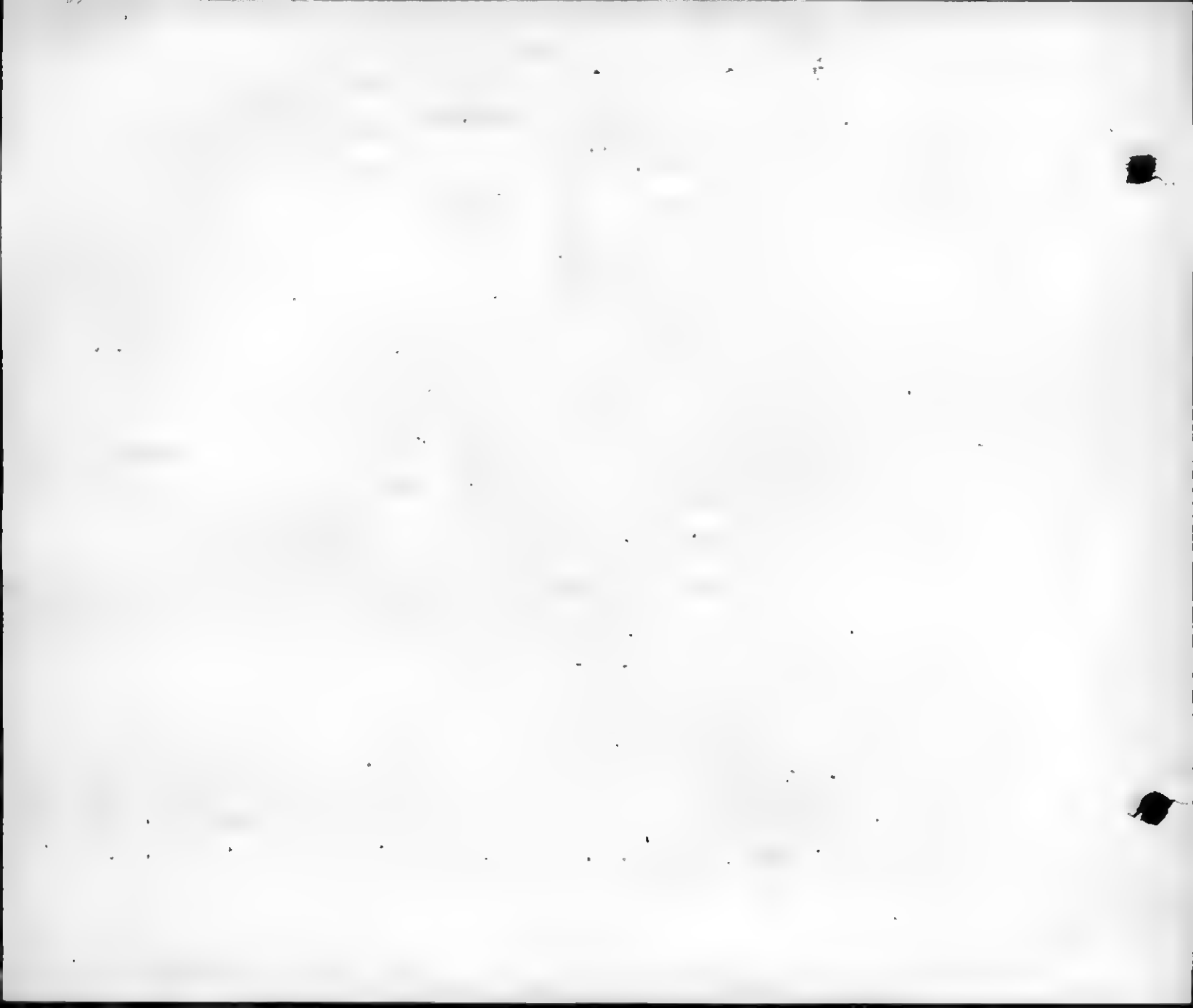
CERTIFICATE OF DEATH

08722

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN Ib <b>31 yr. 10mo. 6 days</b>			
d. NAME OF HOSPITAL (If not in hospital give street address) <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Theodore</b> Middle <b>Wallace</b> Last <b>Waters</b>				4. DATE OF DEATH Month <b>8</b> Day <b>10</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1900</b>	
9. AGE (in years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>James C. Waters</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Louisa Pearce</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO <b>Unknown</b>		INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia and Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Chronic Urinary Retention with Cystopyelitis</b> DUE TO (c) <b>Prostatic Hypertrophy</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic Reaction, Paranoid Type</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>-----</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>	
20f. (City or town) (County) (State) <b>-----</b>							
21. I certify that I attended the deceased from <b>10/4</b> , 19 <b>27</b> , to <b>8/10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/10</b> , 19 <b>59</b> , and that death occurred at <b>12:05 A.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>8/10/59</b> ACTUAL SIGNATURE <b>Lionel McHenry Mapp, M. D.</b> M.D. <b>Crownsville State Hospital, Md.</b> <b>8/10/59</b> PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b> <b>Crownsville State Hospital, Md.</b> <b>8/10/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>a. none</b>				22b. DATE THEREOF <b>8-13-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Community Memorial</b>	
22d. LOCATION (City, town, or county) (State) <b>-----</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Madison Reese</b>				ADDRESS <b>4108 Washington</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 17 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hand</b>							

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

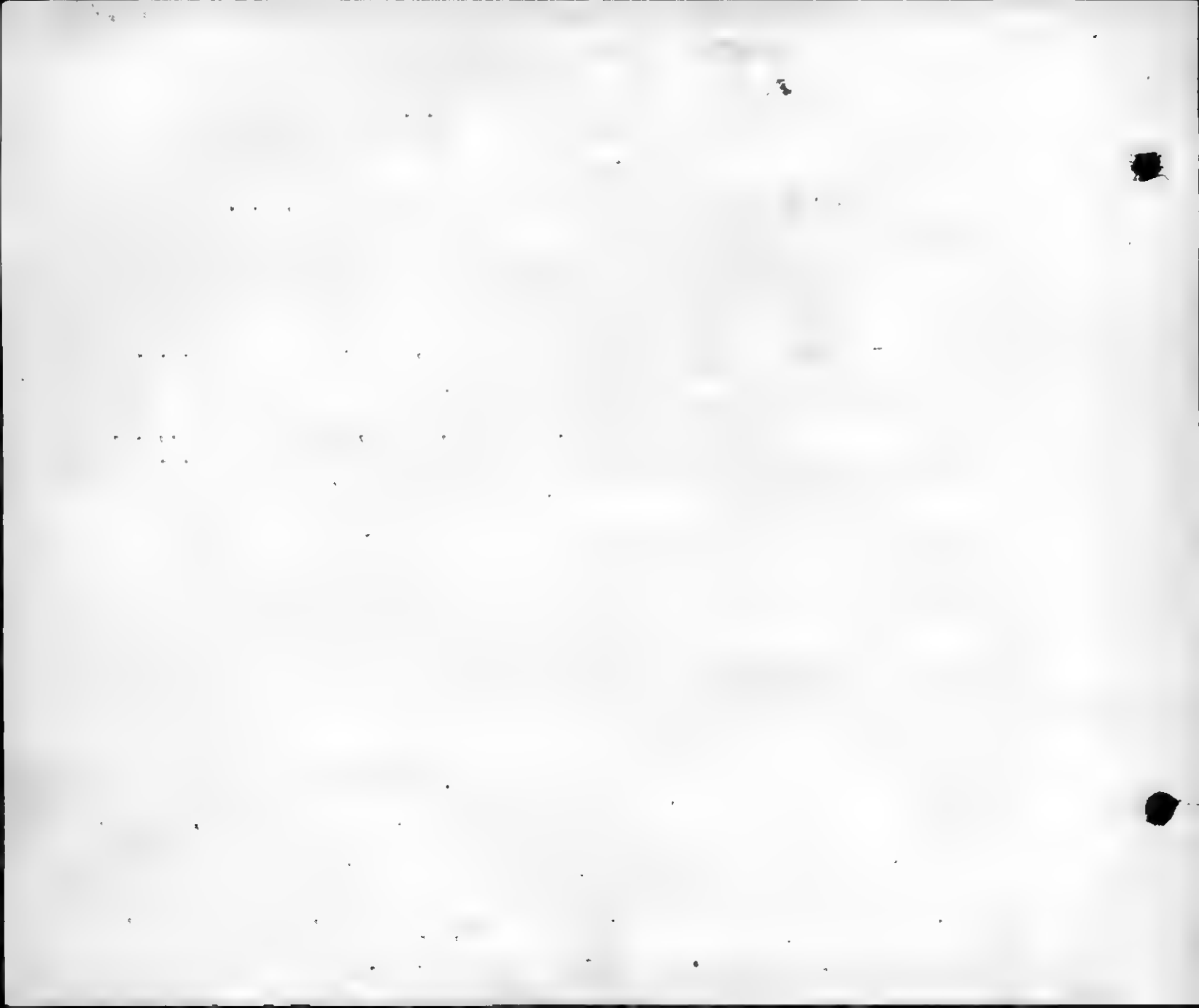
08723

8688

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>				c. LENGTH OF STAY IN 1b <b>1 hr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> 4:00 x	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ANNE ARUNDEL HOSPITAL</b>				d. STREET ADDRESS <b>5028 LOWELL STREET, N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>YELL</b> Middle <b>F</b> Last <b>WEBER</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>13</b> Year <b>19 59</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/15/71</b>	
9. AGE (In years last birthday) yrs. <b>88</b>		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>13</b>		11. IF UNDER 24 HRS Hours <b>1</b> Min. <b>12</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER - retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>OMAHA, NEBRASKA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>WILLIAM FITCH</b>				14. MOTHER'S MAIDEN NAME <b>MARY ELIZABETH LEE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>NONE</b> Address <b>Mr. Donald R. Weber, 5028 Lowell St., N.W. Washington, D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>422.1 ACUTE PULMONARY EDEMA</b> DUE TO (b) <b>ARTERIOSCLEROTIC CARDIO-VASC. DIS-</b> DUE TO (c) <b>1 YR</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PNEUMONITIS-</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>8/12, 1959</b> to <b>8/13, 1959</b> that I last saw the deceased alive on <b>8/13, 1959</b> and that death occurred at <b>4:10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>121 CATHEDRAL ST. ANNAPOLIS, MD</b> DATE SIGNED <b>8/13/59</b> ACTUAL SIGNATURE <b>Richard N. Peeler</b> PHYSICIAN'S NAME (Type) <b>RICHARD N. PEELER</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>TRANS. &amp; BURIAL</b>		<b>8/17/59</b>		<b>WEST LAWN CEMETERY</b>		<b>OMAHA, DOUGLAS COUNTY, NEBRASKA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard N. Peeler</b>				24a. REC'D BY REGISTRAR <b>8/13/59</b>		24b. REGISTRAR'S SIGNATURE <b>Cashin S. House</b>	



8688

## CERTIFICATE OF DEATH

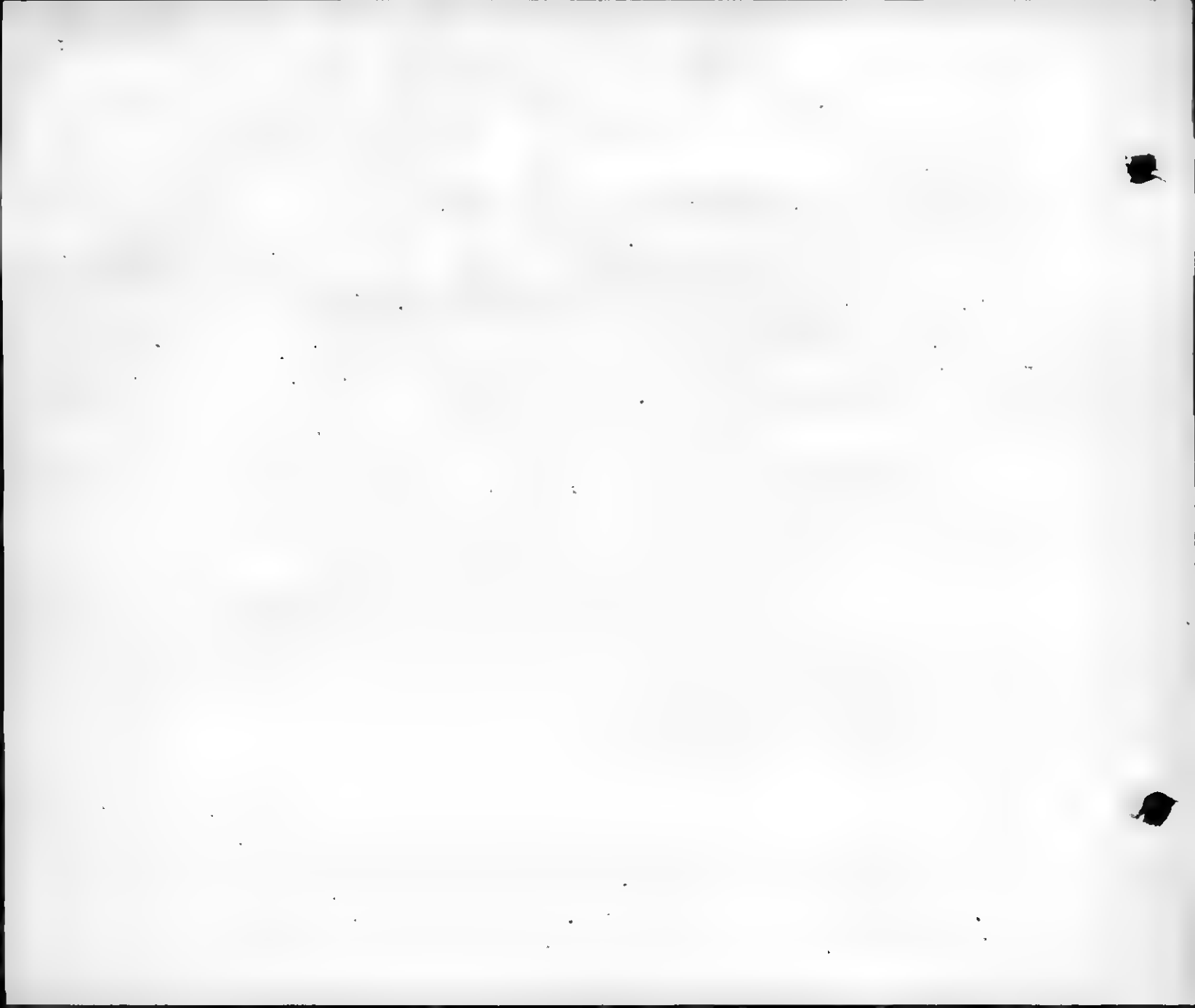
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>10</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
f. STREET ADDRESS <b>86 State Circle</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Robert Selhman Gray WELCH</b>		4. DATE OF DEATH Month Day Year <b>August 5 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 13, 1892</b>
9. AGE (In years last birthday) <b>66</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Ear, Ear, Throat</b>	
13. BIRTHPLACE (State or foreign country) <b>Annapolis Md</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.H.</b>	
15. FATHER'S NAME <b>William S. Welch</b>		16. MOTHER'S MAIDEN NAME <b>Isabella Waterman Gray</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		18. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Sarah Bond Welch</b> Address <b>(2)</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Staph (long +) pneumonia</b> <b>491X</b> DUE TO (b) <b>acute pulmonary emboli</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20. INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b> <b>3 wk.</b>			
21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
24. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		25. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
26. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		27. (City or town) _____ (County) _____ (State) _____	
28. I certify that I attended the deceased from <b>7-31-59</b> to <b>8-5-59</b> , that I last saw the deceased alive on <b>8-5-59</b> , 19 _____, and that death occurred at <b>11:40 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank M. Shipley</b> M.D.		DATE SIGNED <b>8-3-59</b>	
PHYSICIAN'S NAME (Type) <b>Frank M. Shipley</b>		ADDRESS (Street, city or town, state) <b>Annapolis, Md</b>	
29a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		29b. DATE THEREOF <b>8-7-59</b>	
29c. NAME OF CEMETERY OR CREMATORY <b>St. James Cemt</b>		29d. LOCATION (City, town, or county) (State) <b>Annapolis Md</b>	
30. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor Sons</b>		31. ADDRESS <b>Annapolis Md</b>	
32. REC'D BY REGISTRAR <b>DATE AUG 10 '59</b>		33. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
TSM 9/58



## 8690 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY <u>22421</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington Va.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GENERAL</u>				d. STREET ADDRESS <u>2749-So Glebe Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ADA</u> Middle <u>N</u> Last <u>WEST</u>				4. DATE OF DEATH Month <u>AUG.</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-17-1879</u>	
9. AGE (In years last birthday) <u>80</u> yrs		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Glenwood Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? _____							
13. FATHER'S NAME <u>William H. Anderson</u>				14. MOTHER'S MAIDEN NAME <u>Ruffner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>				16. SOCIAL SECURITY NO <u>none</u>			
17. ADDRESS <u>Langston C. West - 4708-8th St So Arl Va.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 day</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>8-1-59</u> to <u>8-2-59</u> , that I last saw the deceased alive on <u>8-2-59</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank M Shipley</u>				ADDRESS (Street, city or town, state) <u>121 Cathedral St 8-2-59</u>			
PHYSICIAN'S NAME (Type) <u>Frank M Shipley</u>				DATE SIGNED <u>August 2 1959</u>			
22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>REINTERMENT</u>		22b. DATE THEREOF <u>8/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Wash De.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm Lee's Sons Co</u>				ADDRESS <u>300 4th St SE</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 4 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			





## CERTIFICATE OF DEATH

Reg. Dist. No.

VE A15 (4)  
15M 9/55

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> <b>8691</b>		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>C. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>C. A. General</u>		d. STREET ADDRESS <u>1202 Van Buren St</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret Louisa Williams</u>		4. DATE OF DEATH Month <u>8</u> - Day <u>12</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 12 - 1879</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Joseph Puckett</u>		14. MOTHER'S MAIDEN NAME <u>Mary J. Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>-</u>	
17. INFORMANT <u>Andrew Williams</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>IN AN VITATION</u>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) <u>DIABETES MELLITUS, UNCONTROLLED</u>			
(c) <u>FRACTURE RIGHT FEMUR</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ATELECTASIS RIGHT LUNG DUE TO CARCINOMA</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>9</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-5-1959</u> to <u>8-12-1959</u> that I last saw the deceased alive on <u>8-12-1959</u> and that death occurred at <u>9:30 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward J. Beebe</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>8/14/59</u>	
22. I certify that I attended the deceased from <u>8-5-1959</u> to <u>8-12-1959</u> that I last saw the deceased alive on <u>8-12-1959</u> and that death occurred at <u>9:30 P. M.</u> from the causes and on the date stated above.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-15-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		23a. REC'D BY REGISTRAR DATE <u>AUG 17 '59</u>	
23b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>		23c. ADDRESS <u>Annapolis Md.</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08727

8753

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Deale</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>Cherry Hill</b> <b>1 Locust Lane, Traylor Park</b>	
3. NAME OF DECEASED (Type or print) First <b>MELVIN</b> Middle <b>MONTGOMERY</b> Last <b>WOOD</b>		4. DATE OF DEATH Month <b>August</b> Day <b>20</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 23, 1915</b>
9. AGE (In years last birthday) <b>43</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto mechanic</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Louis R. Wood</b>		14. MOTHER'S MAIDEN NAME <b>Mattie Deakins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Louise D. Wood</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO <b>Drowning.</b> Conditions, if any, which gave rise to immediate cause (b) <b>850x</b> (c) <b>850x</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>850x</b>	
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Drowned while fishing from boat.</b>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Drowned while fishing from boat.</b>		20c. TIME OF INJURY Month, Day, Year <b>Found</b> Hour a. m. <b>9:15</b> <b>8/20</b> <b>1959</b>	
20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Herring Bay</b>	
20f. (City or town) <b>Deale</b>		(County) <b>A.A.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Charles S. Petty</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8/20/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/24/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 24 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Finns</b>		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



8754

CERTIFICATE OF DEATH

08728

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>County</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15-56-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hosp.</u>		e. STREET ADDRESS <u>8827 Brookville Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Young</u> Last		4. DATE OF DEATH Month <u>Aug.</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unk</u> <u>1897</u> <u>62</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unk</u>		14. MOTHER'S MAIDEN NAME <u>unk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unk</u> INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>522x</u> <u>Hypostatic Pneumonia</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Alzheimer's Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 13</u> , 1959, to <u>Aug. 1</u> , 1959, that I last saw the deceased alive on <u>Aug. 1</u> , 1959, and that death occurred at <u>10:55 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>CROWNVILLE STATE HOSPITAL</u> DATE SIGNED _____			
ACTUAL SIGNATURE <u>Meredith M.</u> M.D.		PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u> <u>CROWNVILLE MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-6-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>	22d. LOCATION (City, town, or county) (State) <u>Rocky Hill, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert R. Snowden - Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>Aug 5 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

192